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Irish Society of Gastroenterology

usg Ulster Society of Gastroenterology

All Ireland Hybrid Summer Meeting

9-10 June 2022

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Irish Society of Gastroenterology

Welcome Message

Dear Friends and Colleagues,

It is our great pleasure to welcome you all to the joint ISG /USG summer meeting of 2022 in Belfast. As a hybrid meeting, we are delighted to be able to have attendees both on site and virtually. This will be our first opportunity (COVID willing), in a number of years to get together and enjoy the educational program and reconnect with colleagues and neighbours, across the island of Ireland.

Together the scientific committees of ISG and USG have put together a program which I'm sure you will enjoy, covering a variety of themes in both Gastroenterology and Hepatology, with distinguished speakers from across Ireland and abroad. Including talks on "coping with burn out" which I'm sure will be of interest to us all after the stresses and strains of the last few years and a talk on green endoscopy, which is in keeping with my "green ISG" agenda. With that in mind, as with last year's winter meeting, the e-Poster format is retained as is a move towards e-Programs. New for this meeting is the Trainee Committee's Case Presentation Session, which along with the parallel e-poster sessions will rely heavily on your active participation including live voting! I wish our NCHD colleagues the best of luck with their endeavours and hope the technology lives up to our ambitions.

On a more sombre note, I would like to take this opportunity to say a few words in support of our Ukrainian colleagues. The war in Ukraine is causing unimaginable suffering and disruption, and it is incumbent on us all to support them in any way possible. To date, ISG has endorsed UEG, WGO and ESGE, statements of solidarity and their mandates for action. In addition, we have reached out directly to the Ukrainian Society of Gastroenterology to offer assistance. Following feedback, ISG has offered short term sponsored visiting research and clinical observation fellowships, endorsed by the Young UEG Committee. We have opened our meeting to all Ukrainian Society Members and will also donate the proceeds from purchased paper programs along with any profit from the meeting to Ukrainian relief programmes.

Finally, my thanks to Michael and Cora for their expertise and help in putting together the meeting, and to my ISG board colleagues for all their support during the year.

I hope your enjoy the meeting

Yours sincerely,

Professor Deirdre McNamara
President,
Irish Society of Gastroenterology

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Welcome Message

Dear all,

II would like to add to the welcome message from Deirdre McNamara, president of the ISG. We are both delighted to welcome you to this joint all Ireland meeting and is the first meeting since the pandemic to be a predominantly face to face meeting with a virtual element. I am sure we are all excited to meet up with friends and colleagues and to enjoy the educational opportunities and also to network.

In addition to the program highlights, we are also delighted to showcase the work of young, talented, upcoming gastroenterologists and surgeons in the island of Ireland; as keynote speakers, presenters of original research and chairs. We are also delighted that several internationally renowned speakers from the UK, Netherlands, Belgium can join us face to face and virtually to deliver state of the art lectures.

I would like to thank Michael and Cora for organising the meeting, to the USG committee members for their support and fantastic ideas for the program. Thanks also to our industry partners for their ongoing support.

I look forward to meeting all of you and hope you have a great time at this meeting.

Yours sincerely,

Dr Tony Tham
President,
Ulster Society of Gastroenterology

All Ireland ISG / USG Hybrid Gastroenterology Meeting

Europa Hotel, Belfast, 9th & 10th June 2022

Programme

Day 1 Thursday 9th June

09.00-10.00 **Pfizer Satellite Symposium**
Contemporary Management of UC
Speakers: **Prof. C Lees,** NHS Lothian & **Dr P Allen,** Ulster Hospital.

10.15-11.30 **Symposium 1**
Endoscopy Tips and Tricks
Chairs: **Dr Philip Hall,** Belfast Trust
Dr Jan Leyden, Mater Hospital, Dublin

10.15-10.40 ***"Green Endoscopy"***
Dr Bu'Hayee
Consultant Gastroenterologist
Kings College Hospital, London, UK

10.40-11.05 ***Managing refractory oesophageal stricture***s
Dr Roos Pouw
Consultant Gastroenterologist
Amsterdam UMC, Netherlands

11.05-11.30 ***Optimising endoscopic surveillance in IBD***
Prof. Helmut Neumann
Director of Endoscopy
University Medical Centre Mainz, Germany

11.30-11.50 **Coffee /Meet the Industry**

11.50-12.50 **Parallel E-Poster Sessions**
(IBD/Hepatology/Endoscopy/Nutrition, Other GI)
(10 abstracts in each room - 5 mins + 1 min)
Chairs:
IBD: **Mr Tim McAdam,** Belfast Trust
Dr Garret Cullen, St Vincent's University Hospital, Dublin
Hepatology: **TBC,** Belfast City Hospital, NI
Dr Clifford Kiat, Cork University Hospital, Cork
Endoscopy: **Mr Ray Kennedy,** Belfast City Hospital, NI
Dr Subhasish Sengupta, Beaumont Hospital, Dublin
Other GI: **Dr Carolyn Adgey,** Royal Victoria Hospital, NI
Dr Grainne Holleran, St James's Hospital, Dublin

12.50-13.40 **Lunch/Meet the Industry**

13.40-15.00 **Symposium 2**
Hepatology for the Gastroenterologist
Chairs: **Dr Tony Tham,** Ulster Hospital, Dundonald
Prof. John Ryan, Beaumont Hospital, Dublin

13.40-14.00 ***When to refer for elastography***
Dr Conor Braniff
Consultant Hepatologist
Royal Victoria Hospital, Belfast, NI

All Ireland ISG / USG Hybrid Gastroenterology Meeting

Europa Hotel, Belfast, 9th & 10th June 2022

Programme

14.00-14.20 ***Drug induced liver injury***
Dr Omar El-Sherif
Consultant Hepatologist
St. Vincent's University Hospital, Dublin

14.20-14.40 ***Who should we refer for transplant***
Dr Charles Millson
Consultant Hepatologist
York Hospital, York, UK

14.40-15.00 ***Managing colorectal metastases in the Liver***
Ms Claire Jones
Consultant Hepatobiliary Surgeon
Mater Hospital, Belfast, NI

15.00-15.30 **Coffee/Meet the Industry**

15.30-16.30 **NCHD Session Case Presentations including Videos (6 cases)**
Chairs: **Dr Karl Hazel,** Beaumont Hospital, Dublin
Dr Rebecca O'Kane, Ulster Hospital, Dundonald

16.30-17.00 **Best of the Rest - E-Posters**
(Top 6 abstracts to present again)
Chairs: **Dr Shivaram Bhat,** Craigavon Area Hospital, NI
Dr Donal Tighe, University Hospital Mayo

17.00-17.15 **Poster/Case Presentation Awards Ceremony**
Close Day 1

17.15-18.15 **Satellite Meeting Sponsored by Galapagos Pharma**
"A New Advance in UC: Introducing the evidence for Filgotinib in UC´´
Prof Glen Doherty, Consultant Gastroenterologist, St Vincent´s University Hospital
Chair; **Dr Tony Tham,** Consultant Gastroenterologist, South Eastern Health and Social Care Trust

20.00 **Conference Dinner**

Day 2 Friday 10th June

08.00-09.00 **Satellite Meeting Sponsored by AbbVie**

09.00-10.20 **Symposium 3**
IBD
Chairs: **Dr Leah Gilroy,** Royal Victoria Hospital, NI
Dr Mary Hussey, University Hospital Galway

09.00-09.20 ***Managing IBD in the setting of spondyloarthropathies***
Dr Timothy Raine
Consultant Gastroenterologist
Addenbrooke's Hospital, Cambridge, UK

All Ireland ISG / USG Hybrid Gastroenterology Meeting

Europa Hotel, Belfast, 9th & 10th June 2022

Programme

09.20-09.40 ***Small molecules in IBD where will we position them?***
Prof. Séverine Vermeire
Consultant Gastroenterologist
University Hospitals Leuven, Belgium

09.40-10.00 ***New IBD apps for patient management***
Dr Gareth Parkes
Consultant Gastroenterologist
The London Independent Hospital, London, UK

10.00-10.20 ***Surgery for perianal Crohn's***
Dr Christianne J. Buskens
Consultant Colorectal Surgeon
Academic Medical Centre, Amsterdam, The Netherlands

10.20-11.20 **Parallel Best Scientific and Clinical Abstract Sessions (Orals)**
(Clinical in Main Room - 6 Orals in each room)
Chairs:
Clinical Abstracts: **Dr Richard Turkington,** Belfast City Hospital, NI
Prof. Glen Doherty, St Vincent's Hospital, Dublin
Scientific Abstracts: **Dr Rebecca O'Kane,** Ulster Hospital, Dundonald
Dr Fintan O'Hara, Tallaght University Hospital, Dublin

11.20-11.40 **Coffee/Meet the Industry**

11.40-12.00 **Best of the Rest - Oral Abstracts**
(2 Scientific abstracts)
Chairs: **Dr Rebecca O'Kane**, Ulster Hospital, Dundonald
Dr Fintan O'Hara, Tallaght University Hospital, Dublin

12.00-13.00 **Symposium 4**
Other challenges in Gastroenterology
Chairs: **Dr Catriona McKenna,** Antrim Area Hospital, NI
Dr Ramona McLoughlin, University Hospital Galway

12.00-12.20 ***Burnout in gastroenterology and how to cope***
Dr Harriet Gordon
Consultant Gastroenterologist
Royal Hampshire County Hospital, Winchester, UK

12.20-12.40 ***Coeliac disease management when the gluten free diet fails***
Dr Jeremy Woodward
Consultant Gastroenterologist
Addenbrooke's Hospital, Cambridge, UK

12.40-13.00 ***Gastroparesis - Psychosocial aspects***
Dr Peter Byrne
Consultant Liaison Psychiatrist
Royal London Hospital, UK

13.00-13.15 **Meeting close and Awards Ceremony**

Biographical Sketches

Dr Bu'Hayee
Consultant Gastroenterologist
Kings College Hospital, London, UK

Dr Hayee is a Consultant Gastroenterologist at King's College Hospital and has been Clinical Director for Endoscopy since 2020, Co-Director of the King's Institute of Therapeutic Endoscopy and is a Reader in Gastroenterology at King's College London. He is Clinical Advisor to the Digital Care Pathways team in NHS Transformation, Clinical Lead for Sustainability (NHS London), and Clinical Director for the new London Endoscopy Academy.
He is an active member of the Endoscopy Committee for the British Society of Gastroenterology, a Fellow of the AGA and ASGE, and a member of ESGE, ECCO and the Association for Bariatric Endoscopy.

Dr Roos Pouw
Consultant Gastroenterologist
Amsterdam UMC, Netherlands

Roos Pouw is a gastroenterologist and principal investigator at the department of Gastroenterology & Hepatology at the Amsterdam University Medical Centers, the Netherlands. In 2011 Roos obtained her PhD-degree Cum Laude with her thesis entitled "Endoscopic eradication of Barrett's esophagus with early neoplasia." Next to her clinical work, Roos supervises a number of research lines on endoscopic management of early Barrett's neoplasia, and for this work she received the UEG Rising Star award 2020. Furthermore, Roos is active as editorial (advisory) board member for the UEG Journal and Best Practice & Research: Clinical Gastroenterology.

Prof. Helmut Neumann
Director of Endoscopy
University Medical Centre Mainz, Germany

Dr. Neumann is Professor of Medicine at the Department of Internal Medicine at the University Medical Center of Mainz in Germany and CEO & Founder of the GastroZentrum Lippe, a large and renowned private endoscopy center in Germany.

He is actively involved in basic and clinical research in the areas of advanced endoscopic imaging. His main research focus is inflammatory bowel disease, infectious colitis, colon polyps and Barrett´s esophagus.
Dr. Neumann has received a number of awards for clinical excellence and acts as a reviewer for various journals including Nature, The Lancet, Gastroenterology, Gastrointestinal Endoscopy and Endoscopy. Dr. Neumann has also been assigned as a Fellow of the American Society for Gastrointestinal Endoscopy (FASGE) and the Japan Gastroenterological Endoscopy Society (FJGES).
His contribution to the field of endoscopy is officially recognized by the American Society for Gastrointestinal Endoscopy (ASGE) and the European Society of Gastrointestinal Endoscopy (ESGE). Dr Neumann is also part of the governing council of the World Endoscopy Organization (WEO) and acts as chair of the IBD committee of the society.
Dr. Neumann has published over 350 articles in the field of advanced endoscopic imaging and on new and emerging endoscopic devices. His scientific research was published in high-rated journals, including Nature, Lancet Oncology, Nature Medicine, Gastroenterology, Gastrointestinal Endoscopy and Endoscopy. Besides, he holds multiple patents on advanced endoscopic imaging techniques.

Dr Conor Braniff
Consultant Hepatologist
Royal Victoria Hospital, Belfast, NI

Dr Conor Braniff is a consultant hepatologist based in the Royal Victoria Hospital, Belfast.

Dr Omar El-Sherif
Consultant Hepatologist
St. Vincent's University Hospital, Dublin

Omar El-Sherif graduated from Trinity College Dublin. He completed higher specialist training in Ireland during which time he completed a PhD in the clinical pharmacology of HCV antiviral therapy, which included visiting research fellowships at the University of Liverpool and Harvard Medical School. He undertook a fellowship in advanced and transplant hepatology at the Queen Elizabeth Hospital Birmingham, and was appointed as a consultant transplant physician at QEHB before returning to Ireland in 2021 to his current post. His specialist interests include immune-mediated and cholestatic liver diseases, and liver disease in pregnancy and adolescence.

Dr Charles Millson
Consultant Hepatologist
York Hospital, York, UK

Dr Millson was trained in gastroenterology and Hepatology in London and Yorkshire. He was first appointed as consultant transplant Hepatologist in 1998 in Leeds, where he remained until 2012 when he moved to York to set up Liver services. Over the last 10 years notable milestones include, setting up an ODN, pathways with primary care, specialist nurse led viral hepatitis, Level 1 iQILS accreditation and RCP prize for their fledgling MD programme. Current research interests include risk stratification, fatty liver disease & Haemochromatosis.

Ms Claire Jones
Consultant Hepatobiliary Surgeon
Mater Hospital, Belfast, NI

Miss Claire Jones is a consultant HPB surgeon and clinical lead in the regional HPB unit in the Belfast HSCT. She completed her surgical training in Northern Ireland followed by an HPB fellowship in Queens Medical Centre, Nottingham. She has an interest in leadership, having completed the Lady Estelle Wolfson fellowship, RCSEng. She is currently a member of RSC England NI Board and the Ireland representative on AUGIS council. Clinically Claire has a particular interest in pancreatic cancer and minimally invasive HPB surgery.

Dr Timothy Raine
Consultant Gastroenterologist
Addenbrooke's Hospital, Cambridge, UK

Tim Raine is the clinical lead of the IBD service at Cambridge University Hospitals, UK. Tim is the chair of the ECCO (European Crohn's and Colitis Organisation) guidelines committee, and is a lead author on several ECCO guidelines – both current and in development. He serves on the UEG Scientific committee and on the British Society of Gastroenterology (BSG) IBD Clinical Research Group. Tim also leads the IBD trials unit in Cambridge and is chief investigator of several clinical trials. He is an honorary faculty member of the Wellcome Trust Sanger Centre, UK. His research, funded by the Wellcome Trust, CCFA, Crohn's and Colitis UK, OpenTargets and the National Institute for Health Research, focuses on regulation of the gastrointestinal immune system.

Prof. Séverine Vermeire
Consultant Gastroenterologist
University Hospitals Leuven, Belgium

Séverine Vermeire obtained her MD degree at the KU Leuven in 1995 and a PhD at the same University in 2001 on "Genetic Polymorphisms and Serologic Markers in Inflammatory Bowel Disease". She further trained at the Universidad Nacional de Asuncion, Paraguay (1993), at the Welcome Trust Centre for Human Genetics , University of Oxford (1997-1998) UK and at the Montreal General Hospital (McGill University) in Canada (2000–2001). Since 2003 she is staff member at the Gastroenterology Department of the University Hospitals Leuven and is appointed Full Professor of Medicine at the KU Leuven. Since 2016, she is Head of the Department of Chronic Diseases, Metabolism & Ageing (CHROMETA) at the KU Leuven.
Dr Vermeire is actively involved as principle investigator in RCTs with new therapeutic compounds and has been lead investigator on several of these programs. Her scientific work resulted in more than 500 peer-reviewed articles so far and focusses on the role of the microbiome and genetic susceptibility in IBD and on identifying predictive signatures of treatment response. Dr Vermeire participated in the International iCHOM consortium on development of Patient-Centered Outcomes for Inflammatory Bowel Disease.
She was awarded several grants including an Advanced H2020-European Research Council (ERC) Grant (2016-2021) and a VIB Grand Challenges project on microbiota modulation strategies in Inflammatory Bowel Diseases together with Professor Jeroen Raes (2018)
Séverine Vermeire was President of the European Crohn's and Colitis Organisation (ECCO) from 2014-2016 and of the Belgian IBD Research & Development (BIRD) Group from 2011-2013

Dr Gareth Parkes
Consultant Gastroenterologist
The London Independent Hospital,
London, UK

Dr. Parkes trained at Cambridge University and Bart's & the London and was awarded a PhD at King's College London. He now works as the Clinical Lead for Gastroenterology at the Royal London Hospital, Barts Health NHS Trust. His interests include clinical trials in IBD, the role of the microbiota and probiotics and the use of technology in IBD OPD. Gareth has sat on the British Society of Gastroenterology IBD committee, has a range of publications in the field of IBD, GI microbiota and IBS. He is the co-founder and Medical Director of Ampersand Health which has developed the award winning mobile application MyIBD Care utilizing digital technology and behavioral science to improve the lives of patients with IBD as well as developing platforms in other Immune Mediated Inflammatory Diseases.

Dr Christianne J. Buskens
Consultant Colorectal Surgeon
Academic Medical Centre, Amsterdam,
The Netherlands

Christianne Buskens graduated as a medical doctor in 1999. From 2000 until 2003 she worked as a research fellow at the department of surgery, and the department of experimental oncology at the Academic Medical Centre (AMC) in Amsterdam. This resulted in her PhD thesis 'The development of new treatment strategies for oesophageal cancer', which she defended with distinction in 2004. She was trained as a surgeon from 2003 until 2009 at the AMC, Antoni van Leeuwenhoek Hospital (Amsterdam), and Gelre Hospitals (Apeldoorn). After completion of her surgical training, she was granted a fellowship from the Dutch Cancer Organization (KWF) at the department of colorectal surgery in Oxford, United Kingdom. Here, she specialized in proctology and minimally invasive surgery. To combine clinical work with (translational) research, she completed a masters program in clinical epidemiology. In January 2012, she became a staff member of the AMC colorectal surgeons group. Here, her field of interest changed from oncology to IBD. Today, she is a specialized IBD-surgeon treating this fascinating disease in all its complexity, in a multidisciplinary setting. She combines her clinical work with translational research which is funded by an innovative research incentive grant from The Netherlands organisation for health research and development. This grant enables her to spend dedicated research time in the laboratory, and was the basis for some ongoing translational IBD research lines: the role of the mesentery in Crohn's disease, the role of the appendix in ulcerative colitis, and the fundamental characterization of perianal fistulas in Crohn's patients.

Dr Harriet Gordon
Consultant Gastroenterologist
Royal Hampshire County Hospital,
Winchester, UK

Harriet has been a consultant gastroenterologist in Winchester since 2000, Hampshire Hospitals NHS Trust. There she is Associate Medical Director for Workforce and has been British Society for Gastroenterology (BSG) Workforce Lead, and then Director of the Medical Workforce Unit for the Royal College of Physicians. Since then she has continued to address the medical workforce crisis as Chair of the RCP Flexibility and Wellbeing group and the Academy of Medical Royal Colleges Flexible Careers Committee, looking at flexible working and other opportunities throughout a medical career and into retirement. She is also an elected councillor and Trustee for the British Society of Gastroenterology and a Censor for the RCP. She set up the RCP Emerging Women Leaders Programme in 2018 and is an elected member of BSG Supporting Women in Gastroenterology.

Dr Jeremy Woodward
Consultant Gastroenterologist
Addenbrooke's Hospital, Cambridge, UK

Jeremy Woodward was appointed as consultant gastroenterologist in Addenbrooke's Hospital, Cambridge in 2002. A PhD in cellular immunology combined with his interest in nutrition led to a career that includes the UK national intestinal and multivisceral transplant service in Cambridge and the recent establishment of Addenbrooke's as one of the two UK centres for refractory Coeliac Disease. He has developed an integrated clinical artificial service in Cambridge combining innovative practices in enteral feeding access and parenteral nutrition. He introduced the Cambridge Coeliac pathway in 2012 and is a keen proponent of patient empowerment through education in this condition. Jeremy teaches undergraduate physiology and lectures on gastrointestinal pathology and nutrition in Cambridge University Medical school where he is also a communications skills facilitator. He is an associate editor of BMJ, Nutrition, Prevention and Health. His publications include original research in coeliac disease and other enteropathies, intestinal transplantation and nutrition support; chapters on gastroenterology and nutrition support (including the Oxford Textbook of Medicine), and a book – 'The Gastroarcheologist' (Springer-Verlag) outlining the gastrointestinal tract and its diseases in the context of evolution.

Dr Peter Byrne
Consultant Liaison Psychiatrist
Royal London Hospital, UK

Peter Byrne is consultant liaison psychiatrist at the Royal London Hospital, and lead consultant for general hospital psychiatry across four east London general hospitals. He graduated from University College Dublin in 1988, and completed all his medical and psychiatric training in Ireland before his first NHS consultant appointment in 1999. He has worked directly with the Gastroenterology Department of Barts Health since 2016: he provides three outpatient clinics each week, ward consultations as well as collaborative teaching and research activities. A former Director of Public Education for the Royal College of Psychiatrists, RCPsych, he was awarded the Public Educator of the Year Award by the College in 2012; he was Associate Registrar for public mental health 2014-21, when he became co-director of the RCPsych Public Mental Health Implementation Centre. He has written two textbooks Clinical Cases Uncovered (2009) and with Alan Rosen, Early Intervention in Psychiatry in 2016. His recent work relates to the preventable premature mortality of people with mental disorders: https://bit.ly/34wYhh5

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Consultant Gastroenterologist

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Consultant Gastroenterologist

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ISG Board Members

Professor Deirdre McNamara
President ISG
Consultant Gastroenterologist
Tallaght Hospital, Dublin

Deirdre is a graduate of Trinity College Dublin and completed Higher Specialist Training in Gastroenterology in Ireland before travelling abroad to complete periods of training in Interventional Endoscopy in Magdeburg, Germany and Cancer Prevention at the National Institute of Health, USA.
Deirdre was appointed to her first substantive post as a Luminal Interventional Gastroenterologist at Aberdeen Royal Infirmary in 2004. During her time in Aberdeen, she developed additional interests in minimally invasive capsule endoscopy and device assisted enteroscopy.
Deirdre returned to Trinity College and Tallaght Hospital as an Associate Professor of Medicine in 2010. She is Co-Founder and Director of the TAGG Research Centre (Trinity Academic Gastroenterology Group) and was Head of the Department for Clinical Medicine from 2012-2015. Clinically, she helped develop Tallaght's reputation as a centre of excellence for both Device Assisted Enteroscopy and Capsule Endoscopy.
In her spare time, Deirdre can usually be found in wellies outdoors, as a dedicated gardener, rider and dog owner.

Dr Garret Cullen
Hon Secretary ISG
Consultant Gastroenterologist
St Vincent's University Hospital, Dublin

Dr Garret Cullen is a Consultant Gastroenterologist at St. Vincent's University Hospital and an Associate Clinical Professor at University College Dublin. He is the Clinical Lead for Endoscopy in Ireland East Healthcare Group. His main clinical interests are inflammatory bowel disease and therapeutic endoscopy.

Dr Manus Moloney
Hon Treasurer ISG,
Consultant Gastroenterologist
University of Limerick Hospital

Dr Manus Moloney graduated in 1987 from Trinity College Dublin, trained in gastroenterology at the Mater and St James Hospital Dublin before moving to the Liver unit at King's College Hospital in London, training in hepatology and completing an MD thesis on Immunogenetics of Primary Sclerosing Cholangitis. Completed training at Ashford Hospital in Kent and Guy's Hospital. Dr Moloney returned to Ireland in 2000 to take up a Consultant post at Nenagh Hospital and Limerick Regional Hospital, now the University of Limerick Hospital Group. Dr Moloney is currently serving as endoscopy lead for the group, main interests include management of Inflammatory Bowel Disease and interventional endoscopy.

Dr Tony C.K. Tham
Consultant Gastroenterologist
Ulster Hospital, Dundonald, Belfast

Dr Tham qualified from the Queen's University of Belfast's medical school. He trained as a gastroenterologist and physician in the Northern Ireland training program. He completed his training as an Advanced Gastroenterology Fellow in the Brigham and Women's Hospital, Harvard Medical School, Boston, MA, USA.
He is a Consultant Physician and Gastroenterologist in the Ulster Hospital, Dundonald, Belfast. He is the President the Irish Society of Gastroenterology. He is the chair of Ireland's National Clinical Program for Gastroenterology and Hepatology Clinical Advisory Group. He was the Chair of the British Society of Gastroenterology Clinical Services and Standards Committee and formerly the Society's quality improvement and guidelines lead.
He has more than 80 publications in peer reviewed journals. He is the first author of a book entitled "Gastrointestinal Emergencies" which has been published as a 3rd edition and translated into Polish and Chinese. He has contributed to several other book chapters. He has been co-author of guidelines on ERCP, lower gastrointestinal bleeding, Barretts oesophagus, perianal Crohns, non medical endoscopy workforce and UK gastroenterology services. He was the Guidelines Editor for Gut. He is on the International Editorial Board of the journal Gastrointestinal Endoscopy; Associate Editor of the World Journal of Gastrointestinal Endoscopy; Diagnostic and Therapeutic Endoscopy. He has received several awards for being a top reviewer for Gastrointestinal Endoscopy.
He was the Head of the School of Medicine, Northern Ireland Medical and Dental Training Agency (deanery). He is the Vice Chair of the Specialist Advisory Committee for general internal medicine at the Joint Royal Colleges of Physicians Training Board and Training Program Director in General Internal Medicine in Northern Ireland. He is an examiner for the Royal College of Physicians of Edinburgh and also Queen's University.
He has led service improvements for patients in Northern Ireland including those with gastrointestinal consequences in pelvic radiation disease, and inflammatory bowel disease.

Dr Patrick Allen
Consultant Gastroenterologist
South East Trust

Dr Patrick Allen is a Consultant Gastroenterologist working in the South East Trust. He graduated from Queen's University of Belfast in 2002. He completed his training in NI and completed a fellowship in St Vincent's Hospital, Melbourne in Endoscopy and IBD. He has been Secretary for the Ulster Society of Gastroenterology from 2012 to 2017 and was on the organising committee for BIG Meeting 2013 and 2017. He is a BSG IBD committee member and is the BSG Four Nations Chair. His main interests are IBD and Endoscopy.

Professor Laurence Egan,
Professor of Pharmacology
NUI Galway

Prof. Egan graduated from UCG in 1990 (M.B., B.Ch., B.A.O.), and completed internship, house officer and registrar training, based at University College Hospital Galway. He received Membership of RCPI in 1992, and Masters in Medical Science from UCG in 1994. From 1994 to 1999, at the Mayo Clinic in Minnesota he completed further training in Internal Medicine, Clinical Pharmacology & Gastroenterology, receiving American Board certification in those 3 disciplines. NUI Galway conferred an MD in 1999. Prof. Egan then undertook post-doctoral training from 2000 to 2002, in the Laboratory of Mucosal Immunology at the University of California, San Diego, before returning to the Mayo Clinic to take up a consultancy in Gastroenterology, with joint appointment in the Department of Molecular Pharmacology and Experimental Therapeutics. His research focuses on molecular characterization of signaling pathways involved in intestinal epithelial cell stress, death and malignant transformation, and optimization of personalized approaches to biological therapy. In 2005, Prof. Egan was recruited by NUI Galway and the Health Service Executive Western Region as Professor of Clinical Pharmacology/Consultant Clinical Pharmacologist and Head of the Department of Pharmacology & Therapeutics, a position he took up in August 2005. Prof. Egan has served as Interim Director of the HRB Clinical Research facility Galway, as Vice-Dean of Research at the College of Medicine Nursing and Health Sciences at NUI Galway, and as Head of the discipline of Pharmacology and Therapeutics. He was associate editor at Gut, and has been editor-in-chief of the Journal of Crohn's and Colitis since 2014.

Dr Zita Galvin,
Consultant Hepatologist
St. Vincent's University Hospital, Dublin.

Dr. Zita Galvin is a consultant Hepatologist at St. Vincent's University Hospital, Dublin. Zita graduated from the Medical School in University College Dublin in 2008 and also has a degree in Pharmacy from Trinity College Dublin (1999). She completed a post graduate Doctorate of Medicine, in the complications of portal hypertension, at University College Dublin/Mater Misericordiae University Hospital, Dublin (2013). She completed her General Internal Medicine, Gastroenterology and Hepatology training in Ireland before moving to Canada to do a fellowship in Transplant Hepatology at the Multi Organ Transplant Programme at Toronto General Hospital. She was appointed as Assistant Professor at the University of Toronto and Staff Medical Gastroenterologist and Hepatologist at Toronto General Hospital from 2017 to 2021. She is the author of a number of peer-reviewed articles. She has served as a reviewer for a number of medical journals including Journal of Hepatology, Transplantation and Liver Transplantation. Zita is passionate about education, teaching and mentorship. She completed the Master Teacher Program at the Department of Medicine, University Health Network (UHN), Toronto. During her time in Toronto, she was the Director of Education for the Multi-Organ Transplant Program and the Director of the Transplant Hepatology Fellowship Program.

Mr James O'Riordan
Consultant Colorectal Surgeon
Tallaght University Hospital

James O' Riordan MD FRCSI graduated from Trinity College Dublin in 1998 with an honours degree. He completed basic surgical training scheme in Ireland and was awarded Membership of the Royal College of Surgeons in Ireland in 2001. He then undertook a research degree and was awarded the Degree of Doctor in Medicine from Trinity College Dublin in 2004. He then commenced higher surgical training in Ireland, was awarded the Intercollegiate Specialty Exam in General Surgery in 2008 and completed an international colorectal fellowship at the University of Toronto in 2011. He has been working as a consultant colorectal and general surgeon in Tallaght University Hospital and St James' Hospital since 2011. His subspecialist interests include laparoscopic surgery, proctology, colorectal cancer and inflammatory bowel disease. He currently has 47 peer reviewed publications in general and colorectal surgery.

Dr Karl Hazel
SpR Training Representative
Beaumont Hospital, Dublin

I am a fourth year trainee on the Higher Specialist Training in Gastroenterology. I am currently undertaking my MD in RCSI and Beaumont Hospital, investigating the role of bile acids in IBD. I have an interest in all areas of Gastroenterology, with a special interest in IBD and endoscopy. I am delighted to be the trainee representative on the Board of ISG and hope we can continue to provide events for trainees in the vein of our breakout session at the ISG Winter meeting 2020 which was an outstanding success for all involved.

Professor Eoin Slattery
Consultant Gastroenterologist

Professor Eoin Slattery graduated with honours from University College Dublin in 2002. He completed his internship and general professional training at St Vincent's University Hospital. He became a member of the Royal College of Physicians of Ireland in 2005. Thereafter, he commenced higher specialist training in gastroenterology, rotating through St Vincent's Hospital, Beaumont Hospital and St Luke's Hospital Kilkenny.
During his training he obtained a post-graduate Doctorate of Medicine as the Abbott Newman fellow in Inflammatory Bowel Disease at University College Dublin. His translational

research project focused on the beneficial effects of cigarette smoke on Ulcerative Colitis.
Following completion of higher specialist training, Professor Slattery embarked on sub-specialist fellowship training. He was appointed as the Irish Society of Gastroenterology Boston Scientific Advanced endoscopy fellow rotating through the Mater Hospital, Dublin and then on to Beth Israel Deaconess Medical Centre/ Harvard Medical School, Boston, MA. He then proceeded to spend 2 years as the Advanced GI nutrition support fellow in New York Presbyterian Hospital/ Columbia University Medical Centre..
He returned home to Ireland in 2015 where he was appointed as a consultant gastroenterologist at University Hospital Galway. Professor Slattery is also the Saolta group clinical lead for Endoscopy. In 2019 he was appointed as the National Specialty Director for training in Gastroenterology by the RCPI.

Dr Subhasish Sengupta,
Consultant Gastroenterologist
Beaumount Hospital, Dublin / Our Lady of Lourdes Hospital, Drogheda

Dr Subhasish Sengupta works as a Consultant Gastroenterologist at Our Lady of Lourdes Hospital, Drogheda. Dr Sengupta graduated from Calcutta University, India and subsequently obtained his MRCP (UK) in 2000. He successfully completed his Specialist Registrar training (CCST) in Gastroenterology mainly working in Mater Misericordae and Beaumont University Hospitals Dublin in 2007. His worked on 'Adrenergic Control of Gallbladder Motility' and obtained his Masters Degree from University College Dublin (UCD) in 2007. He then undertook his Advanced Interventional Hepato-biliary fellowship at Dublin and Beth Israel Deaconess Medical Center, Boston MA, USA 2007-2008. Apart from doing general GI work between Lourdes Hospital Drogheda and Louth Hospital, Dundalk, he does hepatobiliary procedures (ERCP and EUS) at Beaumont University Hospital, Dublin.
Special Interests: Pancreatico biliary Disease and Inflammatory Bowel Disease.

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Consultant Gastroenterologist
Ulster Hospital, Dundonald, Belfast

Mr Tim McAdam
Consultant Colorectal Surgeon

I am a Consultant Colorectal Surgeon and clinical Lead in Belfast Trust having worked as a Consultant in Aberdeen for 6 years. I was a medical student in QUB and trained in North of Scotland and England. My main interests are management of colorectal cancer, member of specialist endometriosis team and pelvic floor disorders. I am a faculty member for RCSEd surgical skills, NOTSS, RCSEng strategies in emergency surgery. I am a recognised national trainer for laparoscopic colorectal surgery.

Dr Shivaram Bhat
Consultant Gastroenterologist
Hon Secretary USG

Dr Shivaram Bhat is a consultant Gastroenterologist at Craigavon Area Hospital in Northern Ireland. He graduated from Queens University Belfast medical school (2002) with subsequent postgraduate training in Northern Ireland and a clinical fellowship at the John Radcliffe Hospital in Oxford. During his postgraduate training he completed a PhD researching cancer progression in Barrett's oesophagus. His clinical and research interests include inflammatory bowel disease and early detection of GI cancer. He is a bowel cancer screening endoscopist and is the IBD lead for the Southern Health and Social Care Trust.

Dr Philip Hall
Consultant Gastroenterologist
Belfast Trust

Dr Philip Hall has recently been appointed consultant gastroenterologist within the Belfast Trust. He graduated from Queens University Belfast in 2008 and completed gastroenterology training in Northern Ireland. He has a Masters degree in Clinical Education.
He completed an advanced therapeutic endoscopy fellowship in St Michael's Hospital, Toronto in 2017 and has interests in upper GI therapeutics, ERCP and quality improvement.

Dr Richard Turkington
Clinical Senior Lecturer
Patrick G Johnston Centre for Cancer Research
Queen's University Belfast

I am a Clinical Senior Lecturer in Medical Oncology at the Patrick G Johnston Centre for Cancer Research, Queen's University Belfast and an Honorary Consultant at the Northern Ireland Cancer Centre with an interest in upper gastrointestinal cancer. My principle research interests include oesophago-gastric and pancreatic cancer and the analysis of genomic datasets for the discovery of biomarkers and mechanisms of resistance to chemotherapeutic agents.

Dr Rebecca O'Kane,
USG Trainee Representative
ST5 Gastroenterology Registrar
Ulster Hospital, Dundonald

Dr Rebecca O'Kane is a ST5 gastroenterology registrar, completing her specialty training in Northern Ireland. She graduated from Queens University Belfast in 2013. Her interests are in hepatology and she will complete an ATP fellowship in Hepatology in Birmingham and Liverpool.

E Posters IBD Schedule
Thursday 9th June Main Meeting Room - Ballroom

Abstract No.	Title of Paper	First Author's Name	Time
22S104	Iron deficiency anemia versus anemia of chronic disease in inflammatory bowel disease (IBD) patients at Mayo University Hospital.	Ahmed Tawfik	11.50
22S110	Investigation Of Deranged Liver Function Tests And Prevalence Of Primary Sclerosing Cholangitis in IBD Patients	Robert Varley	11.56
22S115	Screening For Hidradenitis Suppurativa In Patients With Inflammatory Bowel Disease Is High Yield	Niamh Kearney	12.02
22S139	Outcome IBD Patients Receiving Ustekinumab Therapy	Olga Fagan	12.08
22S156	Non-specific Terminal Ileitis: The Natural Course of Disease	Jayne Doherty	12.14
22S167	Exercise with Inflammatory Bowel Disease - An Irish Perspective	Caroline Walker	12.20
22S168	An Evaluation Of Faecal Calprotectin In Secondary Care Within The South Eastern Trust	Christy Reid	12.26
22S170	Combination Biologic Therapy in Inflammatory Bowel Disease	Conor Palmer	12.32
22S175	Potential economic benefits to patients of switching from intravenous (IV) to subcutaneous infliximab (SC IFX) in an Inflammatory Bowel Disease (IBD) adult patient cohort.	Usama Al Farsi	12.38
22S181	Maternal and Foetal Outcomes after anti TNF exposure	Aoife O'Sullivan	12.44

E POSTER PRESENTATIONS

ABSTRACT 1 (22S104)

Iron deficiency anemia versus anemia of chronic disease in inflammatory bowel disease (IBD) patients at Mayo University Hospital.

Author(s)
Ahmed Tawfik, Arthur Petrie, Joseph Molony, Yuthiesshan Krishnamoorthy, Grace Harkin, Brian Egan, Donal Tighe.

Department(s)/Institutions
Mayo University Hospital

Introduction
Iron Deficiency Anemia (IDA) is one of the most common extraintestinal manifestations in IBD and one-third of IBD patients have anemia [1, 2]. Ongoing blood loss from chronically inflamed intestinal mucosa and micronutrient deficiency, such as iron and B12 are the main mechanisms underlying the development of anemia in IBD patients. Chronic inflammation, hemolysis, and medication-induced myelosuppression also play roles in the development of anemia [3]. Patients with IDA and concomitant Anemia of Chronic Disease (ACD) tend to have more severe anemia compared with patients with ACD alone [4]. IBD patients with IDA are at high risk for hospitalization and surgery, and IDA impacts health-related quality of life [5].

Aims/Background
To assess the Haemoglobin (Hb), MCV, transferrin saturation, and haematinics (Iron, Ferritin, and vitamin B12 levels) in IBD (Crohn's and ulcerative colitis) patients, attending and followed up at Gastroenterology/IBD clinic at MUH.

Method
Blood levels of 652 IBD patients (180 CD and 472 UC patients) were assessed, via searching the I-lab blood system at MUH. Blood investigations were requested from either the IBD clinic or General Practice (GP). The differentiation between IDA and ACD was performed, according to the laboratory Tests of iron Status.

Results
Blood results of 652 IBD patients were assessed. 7 out of 180 (4%) Crohn's patients were suffering from IDA and it was detected in 25 out of 472 (5.3%) UC patients. 21 % of IBD patients (9 % CD and 12% UC) were diagnosed with ACD. Interestingly, the majority of IBD patients have neither IDA nor ACD (84% CD and 78% UC patients), while only 4% of IBD patients have Megaloblastic Anemia (MBA).

Conclusions
IDA is caused by low iron stores in the body, while ACD is functional anemia of iron-restricted erythropoiesis related to chronic diseases such as cancer, and end-organ failure. The majority of IBD patients followed up at the IBD clinic at MUH were not anemic and they were iron sufficient, i.e. low risk of hospitalization and surgery.

TBA (22S110)

Investigation Of Deranged Liver Function Tests And Prevalence Of Primary Sclerosing Cholangitis in IBD Patients

Author(s)
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Introduction
International studies show 30% of IBD patients develop abnormal LFTs, with approximately 5% having chronic hepatobiliary disease, including Primary Sclerosing Cholangitis (PSC). A large worldwide meta-analysis showed 2.16% pooled PSC prevalence in IBD. EASL recommends ultrasound (US) and Primary Biliary Cholangitis-specific auto-antibody testing for chronic cholestasis in IBD patients, with Magnetic Resonance Cholangiopancreatography (MRCP) if negative. Little data exists on rates of abnormal LFTs and PSC in the Irish IBD population.

Aims/Background
To quantify rates of abnormal LFTs, cholestatic pattern LFTs and PSC in IBD patients at a single centre; to assess adherence to the above EASL guidelines.

Method
Retrospective analysis of laboratory, radiology and histology data from our database of 747 IBD patients, to determine LFT derangement, pattern and monitoring; further diagnostic testing - US, MRCP, liver biopsy; and, ultimately, whether PSC was diagnosed.

Results
Patients had UC (63.9%), CD (26.6%) and IBDU (9.5%). 587 (78.6%) had LFTs checked in the past year. 245 (32.8%) had abnormal LFTs when last checked. Among patients with cholestatic LFTs (n=94), 46.8% had US, 20.2% had MRCP, 6.4% had liver biopsy with 6.4% diagnosed with PSC. 8 patients (1.1%) overall were diagnosed with PSC.

Conclusions
In keeping with international data, almost one third of our IBD patients have abnormal LFTs. This study highlights the need for appropriate investigation, with this database enabling improvement. A part-time hepatologist has been approved for Mayo University Hospital - this should improve management and awareness of patients with liver disease going forward.

TBA (22S115)

Screening For Hidradenitis Suppurativa In Patients With Inflammatory Bowel Disease Is High Yield

Author(s)
N. Kearney 1,2,3, P. Girod 4, C. McCourt 3, D. O'Kane 3, R. Hughes 1,5, J. Sheridan 6, B. Kirby 1,5.

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1 Department of Dermatology, St. Vincent's University Hospital Dublin, Ireland; 2 School of Medicine, University College Dublin, Ireland; 3 Belfast Health and Social Care Trust, Belfast, Northern Ireland; 4 School of Chemistry, University College Dublin, Ireland; 5 Charles Institute of Dermatology, University College Dublin, Ireland; 6 Department of Gastroenterology, St. Vincent's University Hospital Dublin, Ireland.

Introduction
Patients with inflammatory bowel disease (IBD) have an increased risk of hidradenitis suppurativa (HS) estimated at 6–23% in healthcare database studies and prospectively in patients screened utilising non-validated questionnaires.

Aims/Background
Our aim was to evaluate validated HS screening questions with a high sensitivity and specificity in patients with IBD to identify prevalence rates and demographic factors associated with co-morbidity.

Method
Questionnaires were distributed to patients attending IBD clinics over three months. Patient records were reviewed to identify demographic and treatment data.

Results
We identified 133 patients with 99 completed questionnaires. 16 patients answered yes to one or more screening questions (16.2%). Comparison was completed between screen-positive and screen-negative patients. There was no difference by age (p=0.680), gender (p=0.344), smoking status (p=0.576), IBD type (p=0.701), perianal IBD (p=0.719) or biologic use (p=0.645). Screen-positive patients had a higher mean weight (88.4kg v 76.4kg, p=0.018) and were more likely to have a family history of HS (p=0.002). Two screen-positive patients have been reviewed in-person with a diagnosis of HS confirmed.

Conclusions
Overall, we report a 16.2% prevalence of reported HS symptoms using validated screening questions in patients with IBD. Patients with IBD who reported HS symptoms were more likely to have a family history of HS and a higher weight. This requires further study with in-person dermatology consultation for all screen-positive patients to confirm the diagnosis. Screening for HS in patients with IBD is high yield and it is important for clinicians who manage IBD to be aware of this association and utilise validated screening questions.

TBA (22S139)

Outcome IBD Patients Receiving Ustekinumab Therapy

Author(s)
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Department(s)/Institutions
Gastroenterology, University Hospital Galway

Introduction
A subset of patients with IBD do not respond to USTE at standard dose of 90mg every 8 weeks. Data is lacking of the efficacy of shortening the interval between dosing.

Aims/Background
To evaluate the outcome of patients with inflammatory bowel disease (IBD) receiving Ustekinumab (USTE) treatment

Method
We performed a retrospective study examining all IBD patients treated with USTE. Data were obtained from electronic health records.

Results
72 IBD patients were assessed: 73% Crohn's disease (CD), 24% Ulcerative colitis (UC), 43% male, with a median age of 43-years (range: 17-97-years). Clinical response at 12-weeks was seen in 88% (n=52) (10% UC, 90% CD). Average Partial-Mayo-score and Harvey-Bradshaw-Index-score prior to the introduction of USTE (6.8 and 8.8) improved to 1.7 and 3.6 respectively with the commencement of USTE. 85% (n=55) remained on USTE therapy at 6-month follow up and 78% (n=45) at 12-month follow up. 16%(n=12) of total cohort stopped USTE therapy of which 59% (n=7) did not undergo dose-escalation. 26% of the cohort underwent dose escalation, at physician discretion, with one individual undergoing dose de-escalation. 90% of those with dose escalation remained on USTE at 1-year follow up. 82% patients with dose-escalation achieved clinical response.

Conclusions
Ustekinumab is an efficacious therapy for IBD and in particular a promising therapy for UC. Dose-escalation is a common but effective strategy in the use of USTE.

TBA (22S156)

Non-specific Terminal Ileitis: The Natural Course of Disease

Author(s)
Jayne Doherty, Amy O Keeffe, Maire Buckley, Garret Cullen, Hugh Mulcahy, Juliette Sheridan, Kieran Sheehan, Glen Doherty, Gareth Horgan, Robert Geraghty, Edel Mc Dermott

Department(s)/Institutions
Centre for Colorectal Disease, St Vincent's University Hospital, Elm Park, Dublin 4 Department of Histology, St Vincent's University Hospital, Elm Park, Dublin 4

Introduction
Non-specific terminal ileitis is a frequently encountered clinical conundrum. The existing literature provides limited guidance on management or the percentage of patient's subsequently developing Crohn's disease (CD).

Aims/Background
Evaluate the natural course of non-specific terminal ileitis and factors predictive of a diagnosis of CD.

Method
Chart reviews for patients with confirmed histological diagnosis of ileitis from 2015-2020 were included. Patient's characteristics, endoscopic findings, outpatient referrals and/or diagnosis of IBD was collected. Patients with a previous diagnosis of IBD were excluded.

Results
393 patients had histologically confirmed ileitis. 289 were excluded (prior IBD). 104 had non-specific terminal ileitis. 52.4% were male. Median age was 46years. Median time to follow-up was 5.0years. Reasons for endoscopy was as follows; diarrhoea (26%), abdominal pain (18.3%), diarrhoea and abdominal pain (10.6%), weight-loss (3.8%), anaemia (7.7%), other causes (29.8%). 32% (n= 34) of patients went on to develop CD over a 5-year period. 56% of patients without a subsequent diagnosis of IBD were booked for follow-up outpatient appointments. Patients who had ulceration in the ileum were more likely to develop CD compared to those without ulceration (54% versus 25%, p = 0.006). Median faecal calprotectin was significantly higher in patients with a subsequent diagnosis of CD (425µg/mg versus 24µg/mg, p = <0.001) and similar results were seen for Crp levels (19mg/dL versus 6mg/dL, p = < 0.001). On regression analysis, ileal ulceration was not an independent factor associated with subsequent development of CD (p = 0.06), however younger age (p = 0.02) and male gender (p = 0.019) were associated with subsequent development of CD.

Conclusions
Non-specific terminal ileitis has a general benign course and physicians need to be cognisant of who they refer for follow-up in outpatient settings. Factors associated with subsequent development of CD include younger age, male gender and elevated biomarkers of disease activity.

TBA (22S167)

Exercise with Inflammatory Bowel Disease – An Irish Perspective

Author(s)
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Introduction
In addition to the general benefits of exercise, people with IBD can also particularly benefit from the improved fatigue, psychological health, and bone mineral density, that regular exercise provides.

Aims/Background
To assess the perceptions, benefits, and barriers to exercise for people with IBD in Ireland.

Method
Members of the Irish Society for Colitis and Crohn's Disease were invited to complete an online questionnaire about exercise. 259 responses met the inclusion criteria.

Results
• 39% male, 61% female. Mean age 47years. Mean BMI 26.7. 43% UC, 52.5% CD, 4.5% indeterminate. • Exercise amount since IBD diagnosis: 23% increased, 35% decreased, 42% same. • Effect of exercise on IBD: 41% positive, 13% negative, 46% no effect. • Leisure time exercise: 3.5% none, 16% gentle, 9% mainly anaerobic, 39% mainly aerobic, 32.5% anaerobic and aerobic. • 65.5% meet levels recommended by the North American Public Health physical activity guidelines, compared to 64% of the general Irish population. • 57% avoid particular activities because of their IBD: most commonly strenuous exercise, contact sports, and jogging. • 90% experience barriers to exercise: 66% arthralgia, 59.5% fatigue, 49% low energy, 42.5% bowel frequency, 41% facilities access. • Barriers for those with stomas: 85% stoma concerns. Body image (33%vs12%)(p=0.0069) and sportswear (7%vs0)(p=0.011) issues are more prevalent. Bowel frequency (4%vs47%)(p=0.000005) and facilities access (30%vs43%)(p=0.22) are less prevalent. • 94.5% feel exercise improves: 84% mental health, 65.5% physical health, 30% fatigue, 40% more energy.

Conclusions
While promoting the numerous benefits of exercise for people with IBD, it is also important to address any barriers to exercise that they might be experiencing.

TBA (22S168)

An Evaluation Of Faecal Calprotectin In Secondary Care Within The South Eastern Trust

Author(s)
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Introduction
Faecal calprotection (FC) correlates with disease activity in Inflammatory Bowel Disease (IBD). FC testing is rising annually. In Northern Ireland there is currently no funding stream for FC use in secondary care.

Aims/Background
To determine if FC use is appropriate and present a case for funding in secondary care.

Method
Data was collected retrospectively on 100 patients with a FC from South Eastern Health Trust secondary care in January 2019. These patients were split into: Group 1, those with known IBD and Group 2 those without a diagnosis at the time of the first FC. Patient demographics, details on each FC during 2019, subsequent investigations and treatments were collated.

Results
In Group 1 the mean number of FC test per patient was 1.76. 94% were deemed appropriate. 48% of FC tests were due to a possible flare of IBD and of these patients 63.3% did not have any further investigations. For patients with a FC >250 58% had a change in treatment. In Group 2 the mean number of FC test per patient was 1.26. For patients with a FC>50 54% had lower gastrointestinal endoscopy, whereas in patients with a FC< 50 22% had lower gastrointestinal endoscopy.

Conclusions
FC testing was appropriate in the majority of patients. In Group 1, a low FC provided reassurance and prevented further investigations. When elevated it guided escalation in treatment with or without endoscopy. In Group 2 most patients with a low FC did not undergo further investigation for IBD.

TBA (22S170)

Combination Biologic Therapy in Inflammatory Bowel Disease

Author(s)
Conor Palmer Emma McCormick Robert Evans David Kevans

Department(s)/Institutions
Department of Gastroenterology, St James's Hospital

Introduction
Biologic agents are now commonly used as therapy for Inflammatory Bowel Disease (IBD), however, a significant proportion of patients do not achieve remission. Recently new biologic agents which target various molecular pathways have been licensed, leading to consideration of the use of combination biologic therapy in patients with incomplete response to standard therapeutic approaches. Data are currently few on the outcome of combination biologic therapy in IBD patient population.

Aims/Background
We aimed to describe the experience with combination biologic therapy at our centre

Method
Retrospective chart reviewed was performed of patients attending the St James's Hospital from 2019 to 2022 who received combination biologic therapy for IBD. While tofactinib is a small molecule therapy we included patients receiving this agent in combination with a biologic therapy in the study. Combination biologic therapy was defined as concurrent therapy of two of the following agents: anti-TNF therapy (infliximab, adalimumab and golimumab), vedolizumab, ustekinumab and tofacitinib. Baseline demographic information, prior therapy history, endoscopic and laboratory assessments were collected. Disease activity was quantified using Mayo sub-score and Harvey Bradshaw index (HBI) as appropriate. Pre and post-treatment CRP and faecal calprotectin assessments were documented. Continuous variables are presented as median [range] throughout.

Results
The study cohort included 6 patients.1 and 5 patients had Ulcerative Colitis(UC) and Crohn's disease (CD) respectively. Baseline characteristics were as follows: Median age 47 [19-58], 33% female, median disease duration 16 years [7-31]. Number of prior biologic therapies was 3 [2-4]. Proportion of patients on corticosteroids at baseline was 66%. Baseline clinical Mayo subscore and HBI were 2 and 3.4 [0-6] respectively. Combination regimens used were ustekinumab & vedolizumab (3 patients), anti-TNF & ustekinumab

(1 patient), anti-TNF & vedolizumab (1 patient) and ustekinumab &tofacitinib (1 patient). After at least 3 months of combination therapy 83% remained on therapy. Median pre-therapy CRP was 4 [1-10] and faecal calprotectin pre and post therapy was 932 and 418 mcg / mL. One patient withdrew from combination biologic therapy following development of pulmonary embolus.

Conclusions
This case series adds information to the limited literature on the use of combination biologic therapy in IBD. Our series supports the concept that combining biologic agents with different mechanisms of action may be safe and effective in the treatment of IBD and a valuable option in patients with refractory disease. Randomised controlled trials are required to formally evaluate this therapeutic strategy.

TBA (22S175)

Potential economic benefits to patients of switching from intravenous (IV) to subcutaneous infliximab (SC IFX) in an Inflammatory Bowel Disease (IBD) adult patient cohort.

Author(s)
Usama Al Farsi, Jayne Doherty, Maire Buckley, Gareth Horgan, Edel McDermott, Hugh Mulcahy, Garret Cullen, Juliette Sheridan, Glen Doherty

Department(s)/Institutions
Centre for Colorectal Disease, St Vincent's University Hospital, Elm Park, Dublin 4

Introduction
SC IFX has recently been approved by the EMA for use in the treatment in moderately to severely active Crohn's disease and ulcerative colitis. SC IFX is approved for adult's ≥18 years at a single dose of 120mg every 2 weeks, irrespective of a patient's body mass index.

Aims/Background
To identify an appropriate cohort of patients suitable to switch from intravenous (IV) to SC IFX and asses the cost effectiveness of switching to SC therapy

Method
All patients attending IV therapies at SVUH were identified. Basic demographics were collected and each patient was contacted via telephone to identify patients interested in switching to SC IFX and data was collected on work status, time spent attending the infusion suite, average cost spent attending the infusion suite and if patients work has been affected

Results
A total of 167 patients with IBD are treated with IV IFX. Age range 17-76 (Median 38). 104 were male. IFX dosing ranges from 17 receiving 10mgs/kg/q4w) to 28 patients receiving 10mg/kg/q8W. 75% of patents asked would be happy to switch to SC IFX. 60% of the patients spend 3.5 hours at the infusion suite for each infusion. Patients spent an average of 20 Euro for petrol and parking at each attendance. 79% of patients came by personal car, while 15% use either a bus or the dart. 38% said they lose a full day of work and 32% lose a half day of work for each infusion. On yearly basis each patient attending the infusion suite will spend 140 euro on travel cost and 26 hrs in the infusion suite. In total 63 patients lose seven days annual leave per year attending the infusion suite and 53 patients lose 3.5 day per year.

Conclusions
Overall switching patients from IV to SC IFX will be a cost effective mechanism for patients regarding travel cost and from an economical status of absenteeism from work. Switching to SC IFX will give patients greater autonomy over their disease and relieve pressure on the hospital including increasing capacity in the infusion suite, reducing traffic and increasing car parking capacity.

TBA (22S181)

Maternal and Foetal Outcomes after anti TNF exposure

Author(s)
Aoife O'Sullivan, Laura Byrne, Eoin O'Sullivan, Grainne Murphy
Department(s)/Institutions
Department of Gastroenterology CUH, Department of Obstetrics CUMH, Department of Renal Medicine- Royal Infirmary Edinburgh, Department of Rheumatology CUH.

Introduction
This was a retrospective single centre case control study conducted in a Maternity Hospital situated in the South of Ireland. Randomised control trials on biologic medications during pregnancy are lacking and the majority of data regarding safety in pregnancy arise from case series, population data review and cohort studies. The BSG consider anti TNFs 'low risk' and suggest discussing pros and cons of 3rd trimester use with the patient.

Aims/Background
The aim of the study was to investigate maternal and neonatal outcomes in pregnant adult women with inflammatory conditions who were treated with anti-TNF therapy as compared to those who did not receive anti-TNF therapy

Method
The case cohort were exposed to anti- TNF therapy either during or in the three months prior to pregnancy. The control group were patients with inflammatory conditions who did not receive anti – TNF therapy during their pregnancies. Patients were identified from administrative hospital codes for the inflammatory condition of interest. Each electronic record was reviewed systematically from 2017 until 2021.

Results
Of 102 pregnancies, the median age was 34 with a range of 22-46. Maternal and foetal outcomes were not significantly associated with anti- TNF use. Of particular importance, maternal and neonatal infection rates and foetal malformation rates were not increased in the anti TNF group.The primary outcomes were length of gestation, the presence of pre-eclampsia, eclampsia, hypertensive disorder of pregnancy, spontaneous abortion, elective termination of pregnancy, cholestasis of pregnancy, maternal or neonatal infection, stillbirth, ectopic pregnancy, mode of delivery, post partum haemorrhage, gestational diabetes and foetal malformation.

Conclusions
Data regarding decision making in this area is compromised of observational data such as that which is reported here given lack of clinical trials in pregnancy. This study analysed a comprehensive list of primary outcome measures, some of which can be variably reported in the available data. Clear definition of outcome measures can sometimes be lacking in the literature and were provided here. Reassuringly, our data supports the use of anti TNF agents in pregnancy when clinically indicated.

E Posters Hepatology Schedule
Thursday 9th June Rotunda Room

Abstract No.	Title of Paper	First Author's Name	Time
22S102	Early Liver Transplantation (eLT) For The Management Of Severe Acute Alcoholic Hepatitis (AAH) Refractory To Medical Therapy: A Preliminary Study On The Demand For eLT In AAH In Ireland	Aoife Alvain	11.50
22S103	Liver Stiffness vs FIB-4 Based Screening For Liver Disease At The Diabetes Clinic	William Shanahan	11.56
22S111	Calcineurinin inhibitor related neurotoxicity in the Irish national Liver Transplant Unit	Gill Douglas	12.02
22S114	Measuring the alcohol-related hospital burden in Ireland and the impact of Minimum Unit Pricing (MUP) on hospital admissions	Tobias Maharaj	12.08
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TBA (22S102)

Early Liver Transplantation (eLT) For The Management Of Severe Acute Alcoholic Hepatitis (AAH) Refractory To Medical Therapy: A Preliminary Study On The Demand For eLT In AAH In Ireland

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Introduction
In 2011, a French study demonstrated improved survival, and a low rate of relapse post eLT, in a group of carefully selected patients with severe refractory AAH when compared to those who were not transplanted. Other countries have since adopted eLT for this indication.

Aims/Background
To investigate the proportion of patients who present to a tertiary referral center with AAH that fulfill the French selection criteria for eLT, if such a treatment were available.

Method
A retrospective study of patients presenting to UHG with AAH between 2018 and 2021. Three published selection criteria were used to determine hypothetical suitability to eLT; MDF>=32 and Lille score >=0.45, absence of previously known cirrhosis and absence of uncontrolled infection/recent gastrointestinal haemorrhage.

Results
37 patients with AAH were identified. 57% male, median age 49 years with a 6-month mortality of 24.3%. 22 patients had a MDF>32, 17 received a steroid course with 9 non-responders (Lille Score >=0.45). The 6-month mortality for these 9 patients was 55.6%. Overall 22(60%) had a previous diagnosis of cirrhosis; 6(16%) presented with concomitant uncontrolled infection or gastrointestinal hemorrhage, excluding them as hypothetical transplant candidates. Only 2(5.4%) fitted all three criteria.

Conclusions
Our study confirmed the high mortality in patients with non-responder severe AAH. Only 2/37 were identified as hypothetical transplant candidates, using the French study selection criteria, prior to psychosocial assessment. These findings suggest there is a "demand" for eLT in Ireland and that the implementation of such a service would not significantly impact organ availability.

TBA (22S103)

Liver Stiffness vs FIB-4 Based Screening For Liver Disease At The Diabetes Clinic

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Introduction
Fatty liver disease and fibrosis are common in patients with type 2 diabetes mellitus (T2DM). Recently published European Association for the Study of the Liver guidelines have suggested screening such patients using liver stiffness measurement (LSM) or fibrosis-4 index (FIB-4) to exclude advanced fibrosis.

Aims/Background
We started a screening programme at the diabetes out-patient clinic to assess the reliability of the suggested approaches and resulting referrals.

Method
In this prospective study, consecutive patients attending for T2DM review at an Irish level 3 hospital between September and November 2021 were screened for liver fibrosis using LSM and had their FIB-4 calculated. The first 100 patients with valid LSM measurements were included in the analysis.

Results
Referral rates to the hepatology clinic varied by modality used. If FIB-4 ≥1.3 criterion was used, the referral rate to the hepatology clinic was 45%; using LSM <8kPa to rule out advanced fibrosis resulted in 34% referral rate; using LSM ≥10kPa to suggest probable compensated advanced chronic liver disease reduced referral rates to 15%. Combining FIB-4 with LSM in a two-step algorithm led to missed potentially significant liver disease in large numbers. 47% patients with LSM ≥8kPa and 33% with LSM ≥10kPa had FIB-4 <1.3.

Conclusions
Screening of patients with T2DM using LSM alone rather than FIB-4 leads to reduced numbers of, and more appropriate, referrals to the hepatology clinic. Shifting from an exclusion (LSM <8kPa) to an inclusion (LSM ≥10kPa) based approach may lessen the potential for screening to overwhelm hepatology services.

TBA (22S111)

Calcineurinin inhibitor related neurotoxicity in the Irish national Liver Transplant Unit

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Introduction
Adverse neurological events are more common following liver transplantation (LT) than in any other solid organ transplantation. Calcineurin Inhibitor related neurotoxicity (CINN) is a common and significant cause of morbidity post LT in up to 40% of patients. While Tacrolimus is the most effective immunosuppressive agent, it is associated with a higher incidence of early severe CINN compared to Cyclosporine. Mild symptoms including tremors, headache and neuralgia are common, however more severe manifestations can occur in a minority of patients including seizures, PRES and psychoses.

Aims/Background
To describe the cohort of patients in the Irish National Liver Transplant Unit who developed CINN and identify risk factors for severe CINN symptoms.

Method
Retrospective review of patients with CINN in St Vincent's University Hospital from 01/01/2000 to 30/06/2020. Patients who were switched to cyclosporine from tacrolimus due to CINN were included in the study. SPSS analysis was used.

Results
1093 LT took place during the study period in 946 patients. 2.6% (n=29) of patients were switched to cyclosporine due to CINN. 76% were male, mean age was 52.7 (SD±9,1), and 38% had alcoholic liver disease. 27% of patients were transplanted for HE and seizures was the most common CINN presentation (24%). Neither MELD, HE, Sodium levels pre LT nor recipient transplant age were associated with severe forms of CINN. Surprisingly, 100% of patients transplanted for viral aetiology developed severe forms of CINN (p 0.048).

Conclusions
Low percentage of CINN was detected, likely due to inclusion criteria bias. Viral aetiology was the only factor associated with severe CINN.

TBA (22S114)

Measuring the alcohol-related hospital burden in Ireland and the impact of Minimum Unit Pricing (MUP) on hospital admissions

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Introduction
Minimum Unit Pricing (MUP) was introduced on 4 January 2022 in Ireland at €1.00. Modelling studies have suggested immediate reductions in admissions for certain alcohol-related conditions.

Aims/Background
To accurately determine alcohol-related hospital burden, and to measure any immediate reduction in alcohol-related admissions from MUP.

Method
Patients presenting to Beaumont Hospital were interviewed from 22:00 to 04:00, over seven nights, before and after MUP. Data included a brief clinical history, AUDIT-C alcohol screening score, and type of alcoholic beverage preference. Attendances were designated as alcohol-related using published alcohol-related ICD codes in Ireland. Alcohol presentations were categorized into 'acute', 'chronic', 'directly-related' or 'partially-related' to alcohol.

Results
There were 245 hospital attendances: 114 pre-MUP and 131 post-MUP. Median age was 49 years old, with 50% females pre-MUP and 51.2% females post-MUP. High-risk alcohol consumption (AUDIT-C score > 5) was similar pre-MUP (43%) and post-MUP (42.0%). With MUP, there was no immediate difference in alcohol-related attendances (31.6% versus 27.5%; p = 0.48) and no difference in alcohol-related admissions (8.8% versus 7.6%; p = 0.75). Acute alcohol-related admissions signaled a 40% reduction (95% CI = 3.9%, 76.1%; p = 0.03) with MUP. Alcohol admissions for 'partially-related', 'directly-related', and 'chronic conditions' did not show any significant difference (p > 0.05).

Conclusions
Almost a third of all hospital attendances and almost a tenth of all hospital admissions are alcohol related. Alcohol is a modifiable risk factor and interventions such as MUP may have an immediate impact on reducing admissions for acute alcohol conditions. Larger sample sizes and longitudinal data are awaited.

TBA (22S116)

A descriptive review of patients with Alcohol Use Disorder at an inner city Dublin hospital.

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Introduction
The management of patients with alcohol use disorder (AUD) places a huge burden on our acute hospitals. These patients often have multiple admissions and require a multidisciplinary approach.
Aims/Background
To conduct a descriptive review of alcohol-related admissions focusing on previous admissions and input from addiction services

Method
Sequential patients admitted with alcohol excess under the hepatology service at Mater Misericordiae University Hospital(MMUH) within a four month period in 2019/2020 were identified using the local admission storage system. For each selected patient we collected the following • No. of previous admissions to hospital • No. of previous admissions secondary to an alcohol-attributable(AA) or alcohol-related(AR) problem. • Evidence of referral to psychiatry

Results
Our total cohort included 29 patients of which 22 (75%) were male. The median age was 51 years and the median MELD was 18. 27/29(93%)of patients (93%) were cirrhotic. 9 patients (31%) had died by the time of this review. The 29 patients had a total of 550 hospital presentations. 60% (n=330) of these presentations were due to alcohol. In patients who had greater than 5 presentations to hospital (n=22,76%), admissions were commonly due to worsening liver disease (μ=5 SD 4.10), trauma/fall/injury (μ=4 SD 4.18), non-specific abdominal pain (μ=4 SD 6.02) and psychiatric illness (μ=3 SD 11.30). Only 12/29 patients (41%) were referred to in-house psychiatric services.

Conclusions
Our patients with AUD have a very high frequency of hospital presentations. Earlier intervention by psychiatry or a focused alcohol counselling team may help to address the underlying dependence and should be better utilized in hospital.

TBA (22S131)

Genetic risk factors for liver fibrosis in the Hispanic/Latino population vary by ancestry

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Introduction
The Hispanic/Latino (HL) population has a high prevalence of NAFLD with more advanced histology compared to other ethnic groups. The variant rs72613567 in HSD17B13 reduces risk of fibrosis; the variant rs738409:G (I148M) in PNPLA3 increases this risk.

Aims/Background
In HL populations, there is limited knowledge about HSD17B13 predicted loss-of-function (pLoF) variants and their interaction with PNPLA3 I148M variant. We evaluated the prevalence and clinical impact of these variants in a HL-enriched patient population in New York City.

Method
BioMe is an electronic health record-linked biobank with ~60,000 participants. We included 8,739 consented adult HL BioMe participants with available genotyping and exome sequencing data. We identified 9 pLoF variants in HSD17B13 and estimated overall prevalence in HL participants, divided into communities defined by genetic ancestry. Individuals with ancestry from Ecuador and Mexico had the highest allele frequency of PNPLA3 I148M (56%/65%) and lowest frequency of HSD17B13 pLoF variants (10%/7%). Individuals with Dominican and Puerto Rican ancestry had the lowest frequency of PNPLA3 I148M (27%/32%) and highest frequency of HSD17B13 pLoF variants (both 22%).

Results
HSD17B13 variants were associated with reduced alanine aminotransferase (ALT, $p=0.04$), aspartate aminotransferase (AST, $p<0.001$) and FIB-4 score ($p=0.03$). PNPLA3 I148M was associated with increased ALT, AST, FIB-4 score and odds of advanced fibrosis (FIB-4 >2.67, OR: 1.59); $p<0.001$ for all. HSD17B13 variants partially mitigated the increase in ALT conferred by PNPLA3 I148M ($p=0.03$).

Conclusions
There was marked variation in allele frequency between ancestral groups, providing genetic evidence that Hispanic sub-populations are not homogenous with consequent variation in risk of liver disease.

TBA (22S142)

Assessing a role for semaglutide in the treatment of non-alcoholic fatty liver disease.

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Introduction
Obesity and type 2 diabetes (T2DM) are risk factors for the development of non-alcoholic fatty liver disease (NAFLD). GLP1 agonists such as semaglutide have a dual mode of action through inducing weight loss and improving blood sugar control and may thus be of benefit in NAFLD.

Aims/Background
To assess the benefits of weight loss secondary to semaglutide in NAFLD achieved through interval measurements of liver stiffness and steatosis grade.

Method
In this prospective study patients who were due to start semaglutide and agreeable to interval screening with transient elastography were enrolled. Patient weight, liver stiffness and steatosis grade were recorded at initial screening and 6 months post semaglutide commencement.

Results
28 patients consented to enrol. To date 5 have discontinued semaglutide due to GI side effects. Of the patients who have been screened at 6-month interval all but one have achieved weight loss, up to 14kg. There has been no incident of worsening liver stiffness. Therre has been a reduction in liver stiffness in 70% of patients. Steatosis grades have been more variable, but we have also seen a reduction in 70%.

Conclusions
Weight loss is the most important treatment modality in NAFLD. Early results demonstrate huge weight loss potential with semaglutide and positive trends in transient elastography. We would hope that this study may lead to a more comprehensive study in NAFLD with an eventual outcome of having semaglutide licenced for the treatment of NAFLD.

TBA (22S152)

Screening for Portal Hypertension. Can We Improve Our Practice?

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Introduction
Upper gastrointestinal bleeding from oesophageal or gastric varices has still a mortality of 15-20%, despite improvements in primary and secondary prophylaxis. Baveno VI guidelines very clearly define recommendations on portal hypertension screening and follow-up. However, we often see patients attending for screening OGD who are already on a NSBB; or who do not meet non-invasive criteria for significant portal hypertension, among others; which increases the waiting list of the Endoscopy units.

Aims/Background
To assess the appropriateness of outpatient OGD for portal hypertension screening according to Baveno VI guidelines.

Method
Retrospective review of all OGDs performed at St. Vincent's University Hospital from 1st February until 30th April 2021. A gastroscopy was defined as appropriate when: a) the indication was

correct (platelets <150,000 and/or Fibroscan >20 and/or previous decompensation) and b) the treatment following of OGD was correct and c) timing from previous and to subsequent (if applicable) OGD was correct. SPSS analysis.

Results
173 OGDs were completed, of which 38.4% (N=45) met the inclusion criteria. 64% were male, mean age was 56.71 years (26-81) and 85% had Child-Pugh A cirrhosis. 49% had an inappropriate OGD: 50% due to not meeting the Baveno Criteria, 20% due to incorrect treatment (e.g. on NSBB at time of OGD) and 30% due to incorrect timing

Conclusions
49% of OGD were not appropriate. Thus, an enhanced knowledge and understanding of the Baveno Guidelines within the Hepatology community may lead to an improvement in treatment and in a decrease in the number of unnecessary gastroscopies.

TBA (22S157)

Thigh Ultrasound in cirrhosis correlates with fat mass on bioimpedance analysis: Higher fat mass, lower muscle mass and reduced muscle are seen in patients with cirrhosis

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Introduction
Sarcopenia (low muscle mass, strength, and function) is associated with adverse outcomes in cirrhosis. Thigh US may be a low-cost tool to identify sarcopenia.

Aims/Background
Validation of anterior thigh US for measurement of total muscle thickness (TMT) and superficial fat thickness (SF) in cirrhosis using bioelectrical impedance analysis (BIA).

Method
A prospective cross-sectional study of functional muscle (handgrip and sit-to-stand) and muscle mass using B-mode US is being carried out in cirrhotic patients and validated using SECA BIA. Stata was used for statistical analysis with t-test and Pearson correlation.

Results
To date, 10 cirrhotic patients (7 ALD, 1 AIH, 1 cryptogenic and 1 NASH) & 7 healthy controls (HCs) were included. Most patients were male (70%), with mean age 59.5yrs (SD=8.5), mean weight 94.18kg (SD=21.4), BMI 31.65kg/m2 (SD=7.7) and MELD 11.3 (SD=11). HC had lower BMI (p=0.03) and waist circumference (p=0.01). 10% of cirrhotic patients were actively drinking. Mean TMT was lower in cirrhotic cohort vs HC (3.95vs4.82, SD 0.66vs0.71 respectively, p=0.01). Mean Fat mass via BIA was higher in cirrhosis vs HC (34.04vs18.66 kg,p= 0.03). BIA fat mass strongly correlated between overall fat mass and thigh US measured SF (p=0.001). We noted impaired functional muscle strength in patients. Sit-to-stand time was lower in HCs (13.62vs7.7secs, p=0.07), hand-grip strength higher in HC (p=0.01) and HCs were more active (p=0.03).

Conclusions
We note higher fat and lower muscle mass with reduced muscle performance in cirrhotic patients and correlation between thigh US and BIA to date. Further recruitment is underway to increase sample size.

TBA (22S178)

Beaumont Liver Support Service for decompensated cirrhosis – Preliminary impact

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Introduction
Mortality from cirrhosis has increased 400 fold in Ireland over the past 50 years. Admissions due liver disease increased 30% during the COVID19 pandemic. The Liver support service (LSS), a new initiative for individuals with advanced liver disease requiring specialist multidisciplinary input and close follow up, commenced in June 2020 at our unit. The LSS is a consultant led service with specialist nurses and pharmacist support, and a weekly liver support clinic.

Aims/Background
This study aimed to assess the impact of the LSS.

Method
Since June 2020, 407 patients with cirrhosis attending were identified; 106 were enrolled in the LSS. From a random sample of 40 patients, ED attendances, admissions and inpatient bed days were assessed in the 12 months preceding and subsequent to their first liver support clinic.

Results
During 2021, 520 clinic reviews were conducted for LSS patients. Clinic admission rate was 1.4%, DNA rate 4.8%, and mortality 1%. Of the 40 patients reviewed, pre LSS, there were 70 ED presentations, 49 hospital admissions and 382 bed days used. Post LSS, there were 36 ED presentations (49% reduction), 22 hospital admissions (55% reduction) and 187 bed days used (51% reduction).

Conclusions
The burden of liver disease and associated mortality is increasing in Ireland. The introduction of a multidisciplinary liver support service resulted in significant reductions in ED presentations, hospital admissions and hospital bed days used. Such an initiative merits further support and could be scaled nationwide.

Return to Normality

As we approach our first 'face to face' meeting in over two years, we reflect on the pandemic period, the negatives, and some positives. The meetings were better attended in some part, many members just joined in for the presentations which they were really interested in, some logged in and out on a few occasions during the day and meetings were slightly less expensive to organise.

A huge difficulty was to develop a way of accommodating the industry and how to allow them some means of participating in a meaningful way. The industrial videos filled this gap and by and large the industry was happy with this. Some of the videos were novel and even inspirational.

A big plus for ISG was the increase in our membership. While we did not impose a registration fee for logging in to the meetings, we insisted that in order to obtain the login details one needed to become a member of ISG, which brought our membership of the Society over the 300 mark for the first time. All future membership will be routed through our website and no longer be dependent on outdated banking routes. Membership of ISG will as always be an annual deduction.

The big negative especially for our senior members was the inability to network. While the educational benefit of our conferences cannot be undervalued, the lack of meeting face to face, squeezing the flesh and swopping experiences cannot be overstated.

I feel that going forward we will always have some virtual element in our future meetings especially where a principal speaker is unable to travel and may have to withdraw at the 11th hour, it may be easier to attract a late substitute to present virtually.

I should also mention that for obtaining CPD certificates the ground rules are changing. One of these is that RCPI will now require a meeting evaluation form from delegates before a CPD certificate may be issued. Obtaining CPD from UK centres will also be far more stringent in the future.

Recently we have heard lots of ideas and discussions of how best to help our friends in Ukraine. One consideration is how we might extend our training and expertise to trainees in their country. The IT and translation facilities are available to us. We have set up a landing site on the ISG website with this in mind and we are presently populating this area. The ISG agenda will be translated into Ukrainian on this site.

USG are presently going through huge change. The organisation while still defining its structure has added some very young energetic members to its committee under the watchful eye of Tony Tham. The progress in this region has been steadily growing.

Finally, ISG has indeed been well served by our dedicated officers, board members, and scientific team, under the capable leadership of Prof Deirdre McNamara.

Kind Regards,

Michael Dineen
Chief Executive ISG

Irish Society
of Gastreoenterology

ISG Winter Meeting

17th & 18th
November, 2022
Grand Hotel, Malahide,
Co. Dublin.

usg Ulster Society of Gastroenterology

USG Autumn Meeting

will be held on
Thursday 13th
October 2022

E Posters Endoscopy Schedule
Thursday 9th June Copenhagen 1

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TBA (22S105)

Establishing a referral pathway to aid diagnosis of Eosinophilic Oesophagitis

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Introduction
Eosinophilic oesophagitis (EoE) is the commonest cause of food bolus (FB) obstruction. Under-diagnosis of EoE remains a significant barrier to clinical intervention and treatment. Gold standard diagnosis involves Oesophagogastroduodenoscopy (OGD) with histological confirmation. To improve patient outcomes, awareness of EoE in Emergency Department (ED) services is vital.

Aims/Background
To assess the management of patients presenting with FB symptoms to our ED, and compare to current guidelines.

Method
A retrospective analysis was performed. Patients were identified from ED database 'Symphony' from 1st January 2019 to 31st December 2019, using various search terms. We collected data on patient demographics, referral destination and subsequent OGD.

Results
820 patients were identified; attendances not relating to FB symptoms or without clinical data were excluded. 101 (12%) patients presented with FB symptoms. Of this cohort, only 16 (16%) patients were appropriately investigated with upper endoscopy. 41 (41%) patients were discharged from ED with no clinical follow-up; 36 (36%) were referred to ENT, with 3 (8%) referred for OGD. Only 12 (12%) were directly referred to Gastroenterology, with 12 (100%) referred for OGD. Of those referred to GI, 2 (17%) patients had histologically confirmed EoE.

Conclusions
Our study highlighted clear discrepancies in the investigation of EoE in patients presenting with FB to ED and ENT. All patients referred to Gastroenterology were appropriately managed and underwent OGD, as per national clinical guidelines. To ensure a standardised approach in the investigation of EoE and to prevent under-diagnosis, a referral pathway has been formalised.

TBA (22S112)

Unnecessary Referrals For Endoscopy Due To Anemia – A Cost Effective Approach

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Introduction
UHW gastroenterology department established a nurse specialist-led pathway for patients referred with endoscopy requests for anemia. It aims to determine whether the aetiology is iron deficiency and whether endoscopy is indicated. Assessment comprised of a focused history, bloods, and stool testing for FOB and calprotectin.

Aims/Background
To describe the outcomes for patients and the benefits of the pathway

Method
Data was collected from the proformas completed as part of the assessments over a 35 month period, between February 2019 and December 2021

Results
144 attended for assessment over this period. 8 failed to complete the assessment. 8 are still completing the assessment. 16 were listed for urgent bidirectional endoscopy, 22 for routine bidirectional endoscopy, 2 for urgent OGD, 5 for routine OGD, 3 for urgent colonoscopy, 2 for routine colonoscopy. 73 were found to not have iron deficiency anemia and did not warrant endoscopy (9 of which were listed to attend for general gastroenterology clinic review). For 1, menses was the cause for IDA and did not warrant endoscopy, 1 was diagnosed with colon cancer by the time of assessment, 2 had already had recent normal bidirectional endoscopy, 1 had previous diagnosis of HHT. 5 had positive anti-TTG (3 were listed for routine OGD to confirm celiac disease).

Conclusions
54% were deferred from endoscopy. The assessment allowed triaging of the remaining patients according to risk. Compared to a conventional approach of indiscriminately investigating all patients with bidirectional endoscopy, this pathway created substantial reductions in waiting lists, risks to patients, and costs to the hospital.

TBA (22S126)

Endoscopic Resection of Colorectal Polyps Involving the Appendiceal Orifice: A Specialist Approach for a Unique Polyp Subtype.

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Introduction
Endoscopic resection of colonic polyps that involve the appendiceal orifice (AO) is challenging and management has traditionally been surgical. More recent data support endoscopic management of these lesions.

Aims/Background
To describe characteristics, endoscopic management techniques and outcomes for a series of appendiceal orifice (AO) polyps.

Method
This was a retrospective review of a prospectively maintained database of AO polyps managed by endoscopic mucosal resection (EMR) at two high-volume academic centres. Resection technique was not standardised across centres. Polyps were described using Jacob classification.

Results
The case series includes 19 patients, median age 67 years (range 43-85 years). Polyps divided similarly between protruded lesions (47.4%) and flat elevated lesions (52.6%) and between adenomas (52.6%) and sessile serrated lesions (47.4%). The majority of polyps (78.9%) were Jacob Type 2 and the remainder were Type 0 (15.8%) or Type 3 (5.3%). Piecemeal cold EMR, traditional EMR and en bloc EMR were performed in 52.6%, 31.6% and 15.8% of cases respectively.

Snare tip soft coagulation (STSC) was applied in 47.4% of cases and clips were used in 47.4%. The only complication reported was intra-procedural bleeding in one case. Of 17 patients who had at least one site check documented, 11.7% had recurrence not amenable to endoscopic resection and were referred for surgery. Another 23.5% had recurrence cleared endoscopically at first site check. The total recurrence rate after first site check was 11.7%.

Conclusions
Recurrence and complication rates were in keeping with previous series. Post-resection clip application was in fewer than half of cases. This may have been due to concerns about appendicitis and is supported by absence of any case of post-resection appendicitis. A standardised approach to endoscopic reporting, polyp characterisation and resection should be encouraged.

TBA (22S129)

Good for the environment and the pocket– An Audit of Waste Generation and Recycling Practices within Endoscopy

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Introduction
Ireland has one of the highest greenhouse gas emissions per capita in the EU, at 13.3 metric tons of CO2 equivalent per person. Healthcare accounts for 30% of all public sector greenhouse gas emissions. General waste accounts for almost 60% of all waste generated in Irish hospitals. It has been estimated that one third of this could be recycled. A large volume of recyclable waste is generated in Endoscopy, however sustainable practices are not currently championed

Aims/Background
This quality improvement project sought to determine the volume of recyclable waste generated within Endoscopy and the cost-effectiveness of introducing green recycling bins.

Method
Total waste generated by patient-related activity during one week was audited. Non-clinical and clinical waste was weighed and sorted. The percentage of recyclable waste was documented and the net cost savings calculated. The net savings on an annualised basis was estimated. Reduction in carbon dioxide emissions (CO2e) were calculated.

Results
In total, 70 non-clinical and 56 clinical waste bins were collected. The median weight for non-clinical waste bins was 20.1kg (IQR 19.7-21.7kg) and 40kg (IQR 28.8-39.0kg) for clinical bins. A median of 14.1kg (70.5%) of non-clinical waste and 3kg (7.5%) of clinical waste was recyclable. Disposal cost/tonne is summarised in Table 1. Net savings of €337/week by sorting 60.1kg was generated (Figure 2), and a reduction in carbon footprint by 21.7kg CO2e. This equates to a cost saving of €17,525 per year (Figure 1), and a reduction in CO2e of 1,128.4kg (Figure 3).

Conclusions
This audit highlighted the impact sustainable practices can have on reducing the inappropriate use of non-clinical and clinical waste bins in Endoscopy. A considerable volume of waste generated can be recycled with significant cost savings.

TBA (22S148)

Serrated Polyp Detection And Pathology Reporting Trends Over Ten Years Of Colorectal Cancer Screening In Northern Ireland

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Introduction
The Northern Ireland Bowel Cancer Screening Programme (NIBCSP) has been operational since 2010, providing a high-quality pathology database of all related colonoscopy specimens and associated diagnoses. Endoscopist and pathologist awareness of, and diagnostic criteria for, serrated polyp subtypes have evolved over this timeframe.

Aims/Background
To describe diagnostic trends relating to NIBCSP polyps, with a focus on serrated polyp subtypes.

Method
All pathology diagnoses from NIBCSP-related colonoscopy procedures, up to year 10 of NIBCSP, were included in the study. Diagnostic trends were reported by NIBCSP year for conventional adenomas and serrated polyp subtypes. Chi-squared tests were used to assess polyp classification and trends.

Results
23,785 diagnoses from 12,442 colonoscopy procedures relating to 9111 patients were included in the analysis. As a proportion of total diagnoses, conventional adenoma diagnoses consistently ranged from 65.6% to 69.8% over the study timeframe. The proportion of total serrated polyp diagnoses also varied little, ranging from 18.6% in year 1 to 16.6% in year 10. However, this masked significant changes in relative proportions of the two commonest subtypes of serrated polyp: sessile serrated lesions increased from 1.3% of all diagnoses in year 1 to 7.0% of all diagnoses in year 10 ($p < 0.001$) whereas hyperplastic polyps declined from 17.0% to 9.5% over the same timeframe ($p < 0.001$).

Conclusions
Evolving pathologist awareness and diagnostic criteria have contributed to increased diagnoses of sessile serrated lesions within the NIBCSP. This has implications for consideration of the optimal definition of serrated polyp detection rate as a quality marker for endoscopy.

TBA (22S160)

Periampullary Diverticula – A retrospective study on the incidence, demographics and impact on outcomes during endoscopic retrograde cholangiopancreatography

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Introduction
Periampullary diverticula (PAD) are commonly found at endoscopic retrograde cholangiopancreatography (ERCP), with an incidence between 6 – 27%.
Aims/Background
The aim of this study was to evaluate the incidence of PAD in our cohort, and to examine the impact on successful outcomes.

Method
A retrospective study was carried out. All patients attending for ERCP between 2015 and 2020 were identified.

Results
From 1000 patients (51.3% female), 1373 procedures were performed. Of these, 161 patients (16.1%) had PAD (192 procedures). Mean age in those with PAD (m=75 years, SD=11.63) was statistically higher than those without (m=67 years, SD=17.41, $p < 0.01$). Biliary stones (n=154,80%) was 2.9 times more likely (95% CI 2.0 – 4.2, $p < 0.01$) to be the indication for procedure in patients with PAD, versus those without PAD (n=687,68.7%). Other indications included liver enzyme derangement (n=15,7.8%), and cholangitis (n=11,5.7%). In comparison, 312 (31.2%) procedures were for abnormal liver enzymes and 98 (9.8%) for cholangitis in the group without PAD. In patients with PAD, 173 procedures were successful (139 procedures with complete duct clearance; 34 with stent insertion). 19 procedures failed, all (9.4%) due to failure in cannulation. There was no significant difference in outcomes in type 1 PAD (n=46) versus other PAD (n=144, p=0.40). 81 (8.1%) procedures failed in patients without PAD, 36 (3.6%) due to failure to cannulate, 31 due to anatomical variation and 6 related to sedation.

Conclusions
In our cohort, PAD are more common in older patients. The primary indication for ERCP in patients with PAD is more likely to be biliary stones, with similar rates of success across both groups.

TBA (22S171)

Higher sedation rates and increased colonoscopy procedure time in patients with Inflammatory Bowel Disease: a review of national endoscopy data over a 6 year period.

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Introduction
IBD patients make up an important sub-group of those accessing endoscopy services with unique anatomical and disease-related considerations. Comprehensive assessment of endoscopic disease activity and mucosal healing is central to therapeutic decision making in IBD. Studies have demonstrated that a higher proportion of IBD patients experience significant discomfort at colonoscopy.

Aims/Background
The aims of the study were to assess the volume, safety, quality, outcomes and patient tolerability of colonoscopy in patients with IBD in Ireland.

Method
We reviewed de-identified national endoscopy procedure data on all colonoscopies performed over a 6 year period in 24 hospitals nationally using the EndoRAAD reporting system.

Results
262,840 colonoscopies were evaluated from 2014-2019. Of these, 199,609 could be confidently identified as being from IBD patients (15,093) and non-IBD patients (184,516) and are analysed here. Caecal intubation rate was marginally higher in IBD patients (92.9% versus 92.1%, $p < 0.001$). The mean (SD) dose of midazolam was 3.86mg(1.93 mg) in IBD versus 3.59mg(2 mg) in non-IBD patients ($p < 0.001$). The mean dose of fentanyl was 59.12mg(33.52 mg) versus 51.45 mg(33.59 mg), ($p < 0.001$). Interestingly, despite the higher requirement for analgesia in IBD, there was no significant difference between the percentage of patients with high levels of discomfort (16.1% IBD versus 15.9% non-IBD, p=0.689), suggesting that higher levels of analgesia are required to achieve equivalent levels of comfort in IBD patients. Mean procedure time was slightly longer for IBD patients (28.7 min versus 26.7 min, $p<0.001$), with 91.1% of IBD patients having mucosal biopsies compared to only 26.3% of non-IBD patients ($p < 0.001$).

Conclusions
This is the largest study to date evaluating patient comfort and sedation in IBD patients undergoing colonoscopy. Further analysis of this large dataset will be key to identifying quality indicators specific to IBD endoscopy.

TBA (22S172)

"Wish You Were Here?"; Examining Postcards From The Caecum

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Introduction
Caecal intubation rate 90% has been identified as a key performance indicator at colonoscopy. In accordance with these guidelines, caecal visualisation should be documented by at least 2 out of 3 landmarks; appendicular orifice (AO), ileocaecal valve (ICV), terminal ileum (TI).

Aims/Background
To examine agreement between three endoscopists (GI SpR, Advanced Nurse Practitioner (ANP), consultant gastroenterologist) regarding adequate photodocumentation of caecal visualisation at colonoscopy.

Method
50 colonoscopies performed in a single unit in 2021 were randomly selected. Photos included in the report (EndoRaad) were reviewed

independently by a GI SpR, ANP and consultant gastroenterologist. Each determined whether the photos clearly identified the AO, ICV and TI. Adequate photodocumentation of caecal visualisation was defined as clear photo documentation of 2/3 landmarks. The data was examined to ascertain if observations amongst the 3 endoscopists were in agreement.

Results
28 females and 22 males were included, mean age of 54.9 years (standard deviation +/- 15.2). Agreement across all 3 endoscopists regarding whether caecal visualisation was adequately documented by 2/3 landmarks was reached in 43 (86%) of cases. In clearly documenting all 3 landmarks, agreement was reached in only 29 cases (58%). AO was most frequently identified by the observers; n=135 (90%), followed by ICV n=103 (68.67%). TI was the least frequently identified; n=91 (60%).

Conclusions
A high level of inter-observer agreement was reached across endoscopists regarding adequate photodocumentation of caecal landmarks at colonoscopy by 2/3 landmarks. However, improvements can be made in clearly photographing all 3 landmarks, particularly TI.

TBA (22S177)

Implementation Of Both BSG 2019 And ESGE 2020 Polypectomy Surveillance Guidelines Safely Reduces The Burden Of Surveillance In A Screening Cohort – A Virtual Model Study

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Introduction
Both BSG and ESGE published new polypectomy surveillance guidelines which encourage a greater number of discharges from colonoscopy surveillance programmes.

Aims/Background
To evaluate the impact of BSG 2019 and ESGE 2020 polypectomy surveillance guidelines within a national FIT-based bowel cancer screening (BS) cohort on surveillance activity and detection of pathology by retrospective virtual application.

Method
A retrospective review of BS colonoscopies performed in 2015-2016 with 5 years prospective follow up in single institution. Index colonoscopies were selected. Incomplete colonoscopies were excluded. Histology of all resected polyps was reviewed. Surveillance intervals were calculated according to BSG 2019 and EGSE 2020 guidelines compared to pre-existing 'European guidelines for quality assurance in colorectal cancer screening and diagnosis' (EUQA 2013). Total number of colonoscopies deferred by virtual implementation of BSG 2019 and ESGE 2020 guidelines were calculated. Pathology identified on procedures that would have been deferred was reviewed.

Results
Total number of index BS colonoscopies performed in 2015-2016 was 890. 115 were excluded (22no caecal intubation, 51 inadequate bowel preparation, 56 incomplete polyp clearance). N=509 colonoscopies were scheduled following index colonoscopy in 2 surveillance rounds based on EUQA. Volume of surveillance was significantly reduced with retrospective application of BSG 2019 – 56.6% (n=221, P value < 0.0001); and ESGE 2020 – 21.2% (n=401 P value < 0.0001. No cancers were detected within the 'potentially deferred' procedures who attended for follow up (n=330).

Conclusions
Both BSG 2019 and EGSE 2020 polypectomy guidelines safely reduce the burden of colonoscopy demand with acceptable pathology findings on deferred colonoscopies.

TBA (22S180)

Automated Prompts Result In High Prokinetic Use Without Improving Colon Capsule Performance.

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Introduction
Colon capsule endoscopy (CCE) relies on timed small bowel and colonic boosters to ensure passage through the gastrointestinal tract resulting in complete colonic visualisation. Prokinetics are recommended for delayed gastric transit (>30 minutes) and can be detected by either direct visual assessment (DVA) or an automated (Alert 0) system.

Aims/Background
To compare the impact of DVA & Alert 0 assessments on CCE performance.

Method
CCE cases were sequentially assigned to either DVA or automated (Alert 0) gastric transit assessment. Patient demographics, metoclopramide use and CCE key performance measures were documented and compared between groups using Chi2 and t-tests as appropriate.

Results
In all 71 patients were recruited (38 DVA and 33 (Alert 0), 66%(n=47) were female, mean age was 60 years. Demographics were similar between groups. Overall CCE completion rate was 76% and diagnostic yield was 66%. In all 36% (n=23) had delayed gastric transit and received metoclopramide. Completion rates were the same in both groups (76%). Diagnositic yield was statistically similar in both groups (72% vs 55%) Significantly more in the Alert 0 cohort received Metoclopramide (64%Alert 0 versus 19% DVA, p<0.0001, OR 9.6, 95%CI 2.9936 to 30.7858). Notably, Metoclopromide use had no significant impact in mean colonic transit times (210mins vs 193 mins), SB transit times (100mins vs 97mins), nor was there any difference in CCE completion rates (70 % v 76%).

Conclusions
This study demonstrates an increase in Metoclopramide use with automated gastric transit assessment, which does not improve CCE completion, and questions the early use of prokinetics in CCE.

E Posters Nutrition, Other GI Schedule
Thursday 9th June Copenhagen 2

Abstract No.	Title of Paper	First Author's Name	Time
22S107	5-Alpha Reductase Inhibitor Use and Risk of Colorectal and Gastro-Oesophageal Cancers in Men with Benign Prostatic Hyperplasia: A Population-Based Cohort Study	Niamh Doherty	11.50
22S120	GI tract dysplasia in the Cystic Fibrosis population- are we screening enough patients?	Ciaran Mc Closkey	11.56
22S123	Impact of the COVID-19 pandemic on acute appendicitis presentation and management within a Northern Ireland population	Dorothy Johnston	12.02
22S125	Clinical Outcomes Following Dietetic Led in Person Education or Virtual Education for the Management of Irritable Bowel Syndrome	Sarah White	12.08
22S130	Palliative Oesophago-Gastric Cancer Pathways and use of Endoscopic Radiologic Palliative Therapy (ERPT) in Northern Ireland for Patients Diagnosed 2018-2019	Sinead Hawkins	12.14
22S136	Unveiling Insights from the Dual ErbB Inhibition in Oesophago-gastric Cancer (DEBIOC) Clinical Trial - A Bioinformatic Analysis	Enya Scanlon	12.20
22S144	Development of a Risk Prediction Model Using Clinical Risk Factors to Stratify Individuals at High Risk of Developing Pancreatic Cancer	Ralph Santos	12.26
22S149	Mean Nocturnal Baseline Impedance: a promising new metric for assessing atypical Gastro-oesophageal reflux disease	Lochlin English	12.32
22S166	Are we going around the twist? A Surge in Intestinal Spirochetosis; Case Series	Niamh Mehigan Farrelly	12.38
22S173	Exploring Patterns in GP Prescriptions of Proton Pump Inhibitors and Histamine (H2) Receptor Antagonists in Northern Ireland between 2013-2020	Victoria Cairnduff	12.44

TBA (22S107)

5-Alpha Reductase Inhibitor Use and Risk of Colorectal and Gastro-Oesophageal Cancers in Men with Benign Prostatic Hyperplasia: A Population-Based Cohort Study

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Introduction
5-alpha reductase inhibitors (5ARi) are commonly prescribed for treatment of benign prostatic hyperplasia (BPH) in men. Pre-clinical evidence suggests that 5ARi's may have a protective role in colorectal and gastro-oesophageal cancer initiation. However, few studies have investigated these associations at the population level.

Aims/Background
This study aimed to investigate the risk of colorectal and gastro-oesophageal cancer associated with 5ARi use in a UK population.

Method
We conducted a retrospective cohort study with active comparator new-user design using the UK Clinical Practice Research Datalink. From a base cohort of patients with incident BPH, we identified new users of 5ARi's and alpha blockers. After a 1-year exposure lag patients were followed up until a first-ever diagnosis of colorectal or gastro-oesophageal cancer, death, end of registration or 31st December 2017. Cox proportional hazards models were used to calculate hazard ratios (HR) and 95% confidence intervals (CI) of incident colorectal or gastro-oesophageal cancer associated with 5ARi use compared to alpha blockers. Additional sensitivity analyses were performed to assess robustness of findings.

Results
We identified 5,018 5ARi and 34,925 alpha blocker new users with an average follow-up of 6.6 years. Overall, 5ARi use was not associated with the risk of colorectal (HR: 1.11 95%CIs: 0.88-1.40) or gastro-oesophageal (HR: 1.14 95%CIs: 0.81-1.60) cancer. The results remained null when repeated for gastric and oesophageal cancer separately. Findings from sensitivity analysis were also consistent.

Conclusions
Overall, use of 5ARi's was not associated with a reduced risk of colorectal or gastro-oesophageal cancer compared to alpha blockers.

TBA (22S120)

GI tract dysplasia in the Cystic Fibrosis population- are we screening enough patients?

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Introduction
Ireland has one of the highest incidences of Cystic Fibrosis (CF) in the world, with approximately 1 in 19 Irish people carrying the gene. With increasing life expectancy, these patients are encountering more extra-pulmonary complications of disease. Data in recent years show a significantly increased risk of GI tract malignancies in this cohort. The reasons for this are thought to be multifactorial including chronic PPI and laxative use, and increasing life expectancy. Whether CFTR modulators play a role or not has yet to be determined.

Aims/Background
To determine the prevalence of GI tract dysplasia in this cohort.

Method
We used the Hospital In-Patient Enquiry (HIPE) dataset to ascertain all patients with CF admitted to SVUH between 2015-2020. Endoscopic and histologic reports were obtained from the hospital EndoRAAD and lab systems respectively.

Results
There were 485 patients with CF that were admitted between 2015-2020. Of these, 184 patients (37.9%) had at least one GI endoscopic procedure in our centre. 123 patients (25.3%) had an OGD with a median age of 39. 12 patients (9.8%) had endoscopic evidence of Barrett's oesophagus, of which 4 (3.3%) had confirmed histologic metaplasia and 1 (<1%) had high grade dysplasia. Prevalence of Barrett's in the non-CF population at a comparable age is estimated at between 2 and 8%. Other diagnoses included; 7.3% benign polyps, 23.6% hiatal hernia (5.7% undergoing fundoplication), 22% gastritis, 6.5% PUD, 8.1% Varices. 54 patients had a colonoscopy with a median age of 35, 20.4% had tubular adenomas with low grade dysplasia, 5.6% had tubulovillous adenomas and 1.9% had metastatic adenocarcinoma.

Conclusions
Our study found significantly higher rates of GI tract dysplasia in this population, both upper and lower GI. It is possible that the increase in Barrett's is due to chronic oeosphagitis and gastritis as opposed to being attributable to the genetic mutation.. Despite established colonoscopy screening guidelines, there are no upper endoscopy guidelines for this cohort, with more work needed to be done in this area. As life expectancy continues to improve, it is likely we will see an increasing burden on endoscopy services in years to come. Use of non invasive methods for screening should be evaluated in this population.

TBA (22S123)

Impact of the COVID-19 pandemic on acute appendicitis presentation and management within a Northern Ireland population

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Introduction
Acute appendicitis is the most common acute surgical emergency worldwide. Diagnosis is clinical, facilitated by imaging, with appendicectomy the most common management.
Aims/Background
To investigate how the COVID-19 pandemic and subsequent surgical guidance impacted acute appendicitis presentation, management and pathology.

Method
The retrospective study reviewed patients of all ages who had an appendicectomy performed for suspected acute appendicitis and specimens submitted for histopathology assessment to the Belfast Health and Social Care Trust, Northern Ireland. Comparisons were made between pre-COVID-19 (March 2019 to February 2020) and COVID-19 (March 2020 to February 2021) timeframes. Chi-squared tests were applied to compare characteristics between pre-pandemic and pandemic years.

Results
In the pre-COVID-19 year, 675 appendicectomies were performed; this declined to 593 in the COVID-19 year, representing a 12.1% reduction. When compared with pre-COVID-19, fewer patients presented to hospital in the first 24 hours of symptoms during the COVID-19 timeframe (45.0% v 53.2%, p=0.005). More CT imaging was used for diagnosis (46.9% v 37.5%) and fewer patients proceeded to theatre without any diagnostic imaging (41.7% v 48.0%) (p=0.001). Appendix pathology showed an increased proportion with perforated acute appendicitis during COVID-19 (30.9% v 23.6%) and fewer specimens which were normal or showed changes of simple, chronic or secondary appendicitis only (p=0.007).

Conclusions
COVID-19 was associated with delayed presentation of acute appendicitis, increased use of pre-operative diagnostic imaging and reduced numbers of appendicectomy procedures. Consequently, pathology findings were also impacted, with fewer normal specimens and an increased proportion demonstrating perforated acute appendicitis.

TBA (22S125)

Clinical Outcomes Following Dietetic Led in Person Education or Virtual Education for the Management of Irritable Bowel Syndrome

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Introduction
Group education has shown to be effective in the dietary management of Irritable Bowel Syndrome (IBS). During the Covid-19 pandemic patients attending the gut therapy service in TUH received virtual presentations and reviews in place of group education sessions. The impact of this shift in practice had not been evaluated.
Aims/Background
To compare clinical outcomes between in person and virtual education in patients with IBS.

Method
Patients attended dietetic led first line and FODMAP education either in person or virtually. Success with dietetic intervention was determined using the Global Symptom Question (GSQ).

Results
To date, 399 patients have attended first line education and were subsequently discharged. Of those who attended first line education in person 55.7% (n=147/264) reported satisfactory relief of their symptoms vs 72.6% of patients who attended virtually (n=98/135). 172 patients have attended FODMAP education and have been discharged to date. Success rates were marginally higher amongst virtual patients (44.9%, n=22/49) than those who attended in person (39.8%, n=49/123). Additionally 22.4% of virtual patients (n=11) and 13.8% of patients who attended in person (n=17) failed to achieve satisfactory relief of their symptoms post FODMAP education but had success reinstating first line interventions.

Conclusions
A greater proportion of patients achieved satisfactory relief of their symptoms following virtual first line education than in person first line education (72.6% vs 55.7%). A similar proportion of patients who attended FODMAP education in person or virtually achieved satisfactory relief of their symptoms.

TBA (22S130)

Palliative Oesophago-Gastric Cancer Pathways and use of Endoscopic Radiologic Palliative Therapy (ERPT) in Northern Ireland for Patients Diagnosed 2018-2019

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Introduction
For the first time, palliative care pathways for oesophago-gastric (OG) cancer patients, including endoscopic radiologic palliative therapy (ERPT), have been audited in NI. ERPT rates were higher in NI (33%) than those published in the England/Wales based National Oesophago-Gastric Cancer Audit report (15%). Neither audit has analysed the characteristics of patients who undergo ERPT.

Aims/Background
To explore the characteristics of OG cancer patients who undergo ERPT in NI.

Method
Palliative patients were identified within the 2018-2019 NI OG Cancer Audit database. Differences in characteristics (age, sex, comorbidities and socio-economic status based on area of residence) between patients who did and did not undergo ERPT were analysed using chi-squared tests.

Results
Of the total 759 OG cancer patients, 449 (59%) were on a palliative care pathway. Of these, 33% (n=146) underwent ERPT. There were no significant differences in patients who received ERPT according to age groups (36% <70 years v.30% 70+years, p=0.13), sex (34% males v. 29% females, p=0.24) or socio-economic status. (p=0.50). Two thirds (67%) of patients had another co-morbidity recorded; there were no significant differences in ERPT rates between patients who did or did not have a recorded comorbidity (35% v. 28%, p=0.14).

Conclusions
There were no significant differences in ERPT receipt amongst palliative OG cancer patients in NI, based on age, sex, comorbidities, and socioeconomic status. Clinicians should be reassured that there do not appear to be inequalities in ERPT receipt within OG cancer patients, but it remains unclear why rates are higher in NI than other UK regions.

TBA (22S136)

Unveiling Insights from the Dual ErbB Inhibition in Oesophago-gastric Cancer (DEBIOC) Clinical Trial – A Bioinformatic Analysis

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Introduction
Oesophageal Adenocarcinoma (OAC) incidence in the Western world has increased markedly over 30 years. 5-year survival for patients remains below 20% with dismal response to neo-adjuvant or perioperative chemotherapy for operable tumours. The Dual-ErbB Inhibition in Oesophago-gastric Cancer (DEBIOC) clinical trial assessed efficacy of combined oxaliplatin and capecitabine (Xelox) with dual-ErbB inhibitor AZD8931 in providing additional benefit to operable patients compared to Xelox alone.

Aims/Background
We utilised a bioinformatic approach combining Almac ClaraT Total mRNA Report with machine learning methods to unveil translational clinical potential and biological insights from DEBIOC patient biopsy and resection specimens.

Method
Using gene expression of DEBIOC patient specimens with clinical observations, we combined machine learning techniques with Almac's ClaraT Total mRNA report to assess transcriptional changes between treatment types regarding the 10 hallmarks of cancer, characterised by representative gene-expression signatures and scores. These methods were employed to identify possible mechanisms of treatment resistance, evaluate changes in signalling pre and post treatment and determine clinically significant molecular subgroups in OAC.

Results
Comparisons of signature scores per treatment arm revealed Xelox+AZD8931 resulted in significantly lower immune signalling post-treatment compared to Xelox alone, associated with OAC progression events. Clustering revealed different immune phenotypes within HER2-IHC and EGFR-FISH classified OAC biopsy samples, with ROC/AUC analysis highlighting immune signatures as predictors of poor survival outcomes.

Conclusions
Our analysis demonstrates prognostic value of immune signalling in OAC while highlighting heterogeneity of immune phenotypes within HER and EGFR classifications at biopsy, promoting the idea of immune stratification of OAC at biopsy to inform treatment decisions.

TBA (22S144)

Development of a Risk Prediction Model Using Clinical Risk Factors to Stratify Individuals at High Risk of Developing Pancreatic Cancer

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Introduction
Due to relatively low incidence of pancreatic cancer, population-based screening is not recommended. Implementing a risk prediction tool using easily obtained information by clinicians, may enable targeted screening within individuals at higher-risk of pancreatic cancer.

Aims/Background
To develop a risk prediction model for risk of developing pancreatic cancer within five years.

Method
UK Biobank cohort data were analysed from 357,047 individuals aged 50-73 years, with no history of cancer, who completed baseline questionnaire data in 2006-2010. The primary outcome was risk of pancreatic cancer (ICD-10, C25; ICD-9, 157) within six months to five years after baseline. To build the model, logistic regression was performed to estimate the coefficient for each predictor variables (age, sex, smoking, new-onset diabetes, and pancreatitis). Model

performance was assessed using area under the receiver operating characteristics curve (AUROC), sensitivity, and specificity. The model was internally validated by 10-fold cross-validation.

Results
Within 5 years follow-up, 354 individuals developed pancreatic cancer. The model's ability to discriminate between individuals at high and low risk of developing pancreatic cancer was modest (AUROC: 0.67; 95% CI: 0.64 – 0.69), with minimal indication of overfitting during cross-validation. A risk stratification cut-off chosen to give high specificity (97.7%), included 9% of all pancreatic cancer cases leads to an absolute risk of 0.4%.

Conclusions
The clinical risk prediction model for identifying individuals at high risk had modest performance. Addition of biomarkers or genetic factors may potentially improve the predictive capability of the model.

TBA (22S149)

Mean Nocturnal Baseline Impedance: a promising new metric for assessing atypical Gastro-oesophageal reflux disease

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Introduction
The Lyon Consensus 2018 describes mean nocturnal baseline impedance (MNBI) as a reflection of oesophageal mucosa permeability, with lower values found in erosive reflux disease than non-erosive reflux disease (NERD). However, its role in patients with atypical reflux remain to be determined.

Aims/Background
We aim to assess the relationship between MNBI & Acid Exposure Time (AET), in our patient population, with special focus on those with atypical presentation of GORD.

Method
We retrospectively reviewed High Resolution Impedance manometry and 24 hour ambulatory pH and impedance studies of 239 (91 M, 148 F) consecutive patients attending our GI Function Laboratory between February '21 & February '22.

Results
148 of 239 (62.8%) patients were classified as presenting with typical manifestations of GORD. In these patients 55 (37.16%) were found to have abnormal acid exposure time (i.e >4.2%) While 108 (76.05%) were found to have abnormal MNBI (<2292 ohms). 91 of 238 (38.2%) presented with atypical Sx of GORD. 11 (12.08%) of those patients with extra-oesophageal symptoms show elevated AET with 46 (52.27%) showing abnormal MNBI

Conclusions
More than one third of all patients attending our lab for HRiM & 24hour presented with extra-oesophageal manifestations of GORD. AET was abnormal in only ~12% of these patients whereas MNBI was abnormal in more than 50%, possibly underestimating non-acid reflux in this cohort. Further research is warranted to understand the discordance between AET and MNBI which may prove to be a novel screening tool in these atypical patients.

TBA (22S166)

Are we going around the twist? A Surge in Intestinal Spirochetosis; Case Series

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Introduction
Intestinal spirochetosis (IS) involves colonisation of colonic epithelium with Brachyspira aalborgi or Brachyspira pilosicoli. Clinical relevance and optimal management remains debated. Diagnosis of IS on colonic biopsies has been observed on a number of occasions at our centre, particularly in recent years.

Aims/Background
To describe a case series of IS, and to ascertain whether its incidence is increasing.

Method
A prospectively maintained electronic database of pathology reports was interrogated for colonic biopsy reports containing the term 'spirochete' over a >6 year period (January 2016 – April 2022). Relevant reports were reviewed to identify cases of IS. Corresponding colonoscopy reports were reviewed.

Results
Thirteen cases of IS were identified at microscopy and confirmed with Warthin-Starry stain; 5 (38%) female, mean age 54 years (range 30-74). A known history of ulcerative colitis (UC) was documented in 4 (31%) cases. Indication for endoscopy included diarrhoea (n=6, (46%)), IBD assessment (n=3, (23%)), PR bleeding (n=2, (15%)), abdominal pain (n=1, (8%)) and anaemia (n=1, (8%)). Macroscopically, 7 (54%) colonoscopies were normal, 5 (38%) had diverticular disease and 1 (8%) had an adenoma. Microscopically, mild colitis was the only additional finding, observed in 3 (23%) cases, all of whom had known UC. Between January 2016 and April 2021, four cases of IS were identified. Nine cases were identified between April 2021 and April 2022, representing a >10-fold increase in observed cases in the past year.

Conclusions
Incidence of IS appears to be increasing. The significant proportion of cases with UC suggests a possible association between UC and IS.

TBA (22S173)

Exploring Patterns in GP Prescriptions of Proton Pump Inhibitors and Histamine (H2) Receptor Antagonists in Northern Ireland between 2013-2020

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Introduction
Following the withdrawal of Ranitidine from the market in 2019-2020, no population-based study has assessed prescribing trends for Ranitidine alongside those of other prescription medications indicated for use in treating gastro-oesophageal reflux disease.

Aims/Background
To quantify the number of PPI and H2RAs prescribed in NI between 2013 and 2020 and explore prescribing patterns for these medications over time and following the withdrawal of Ranitidine.

Method
Data on H2RAs (Cimetidine, Famotidine, Nizatidine and Ranitidine) and PPIs (Esomeprazole, Omeprazole, Lansoprazole, Pantoprazole and Rabeprazole) prescriptions between October 2013 and October 2020 were obtained from the Open Data NI website. The collated data represents prescriptions from GP practices in NI submitted to Business Services Organisation (BSO) for reimbursement.

Results
Between October 2013 and October 2018, a 21.8% increase in PPI medications prescribed/month from 165,402 to 201,420 prescriptions was observed. Following the voluntary withdrawal of Ranitidine in October 2019 and withdrawal by FDA in April 2020, H2RA prescriptions decreased by 20,923 (91.1%; 22,964 to 2,041 prescriptions) between October 2018 and October 2020. Although PPI prescriptions increased by a further 13,762 during this time period, this only accounts for approximately 66% of the decline.

Conclusions
Following Ranitidine's withdrawal, H2RA prescriptions decreased by 91.1%. Although, approximately 66% of this drop may have been compensated by an increase in PPI prescriptions, these findings also suggest that not all patients previously prescribed Ranitidine were transferred to another H2RA or PPI. GPs may have used the Ranitidine withdrawal as a 'teachable moment' to review medication use. Further research is required to confirm and explain these trends.

Sincere thank you to the Scientific Committee for their time and energy.

Dr Geraldine McCormack
Prof Eoin Slattery
Dr Catriona McKenna
Dr Leah Gilroy

Case Presentations
Thursday 9th June, Main Meeting Room Ballroom

Abstract No.	Title of Paper	First Author's Name
22S127	CASE PRESENTATION When Things Go Bump in the Night	John Campion
22S151	Use Of Rescue Infliximab In Acute Severe Ulcerative Colitis In A Patient With Multiple Sclerosis-A Case Report.	Julie Steen
22S155	CASE PRESENTATION: An unexpected cause of GI Bleeding	Eilis McCarthy
22S164	Rescue tofacitinib following infliximab failure in a patient with corticosteroid refractory acute severe ulcerative colitis.	Emma McCormick
22S185	It's cold inside. Inadvertent Hypothermia during prolonged endoscopy	Fintan O'Hara
22S186	Over the scope clip for treatment of symptomatic benign tracheo-oesophageal fistula (VIDEO PRESENTATION)	Mark McCrossan

TBA (22S127) CASE PRESENTATION

When Things Go Bump in the Night

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Introduction
A 53 year old man was diagnosed with small bowel Crohn's disease in 2000. His disease was complicated by jejunal and ileal strictures, requiring small bowel resection, ileo-caecal resection and repeated stricturoplasty. He was intolerant of Infliximab and Adalimumab, and discontinued Azathioprine due to side effects so was maintained on Methotrexate. In 2013, the patient developed an abdominal wall abscess with enterocutaneous fistula 80cm distal to the duodeno-jejunal flexure and required further surgery.

Results
During outpatient review in 2019, the patient reported reduced intensity of vision, particularly at night, as well as some visual discoloration. There was no relative afferent pupillary defect, extra-ocular movements were normal and there was no pain on eye movement. He did however report a family history of multiple sclerosis and was referred for neurology and ophthalmology review. Optical coherence tomography (OCT) was normal. MRI Brain and orbits showed no evidence of demyelination. In June 2020, due to progressive weight loss, symptomatic anaemia and contrast-enhancement on small bowel MRI , adalimumab was restarted in parallel with enteral feeding via a naso-gastric tube. In August 2020 the patient reported a dramatic deterioration in visual acuity. Ophthalmology were again involved and examination noted decreased visual acuity bilaterally. Visual electrophysiology showed reduced rod responses with a differential diagnosis of cone-rod dystrophy and Vitamin A deficiency. Serum vitamin A level was returned as undetectable. High-dose parenteral Vitamin A supplementation was administered and this was rapidly followed by a recovery of visual acuity to normal. This remained normal at ophthalmology outpatient follow-up twelve months later.

Conclusions
- Malnutrition is common in patients with Crohn's disease, particularly those with extensive small bowel or post-surgical disease. - Micronutrient deficiency can affect up to 40% of patients in this group and should be considered as part of routine clinical assessment. - Nyctalopia (loss of night vision) should prompt investigation for Vitamin A deficiency.

TBA (22S151) CASE PRESENTATION

Use Of Rescue Infliximab In Acute Severe Ulcerative Colitis In A Patient With Multiple Sclerosis-A Case Report.

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Introduction
Acute severe ulcerative colitis is a medical emergency that will affect 1 in 5 patients with ulcerative colitis. While Infliximab(IFX) plays a very successful role in its management, it is generally contraindicated in patients with multiple sclerosis(MS).

Aims/Background
We present the case of a 43 yo female who presented with a 2week history of worsening bloody diarrhoea (7-8/day) in the context of recent covid infection with two previous similar admissions labelled as infectious colitis in 2016/2021. She had a history MS diagnosed in 2003 which was stable and required no subsequent admissions.

Method
On presentation, she was haemodynamically stable and afebrile. Bloods:Hb 9.8g/dL(12-15), WCC 18x10^9/L(4-10), K 3.0mmol/L(3.5-5.3), Albumin 31g/L(35-50), CRP 98. Despite 3 days of IV hydrocortisone her bowel motions remained 6-7/day and her CRP 78mg/L(0-5). Flexible sigmoidoscopy demonstrated severe colitis (Mayo 3) with deep ulceration.

Results
Given the patient's significant reluctance for surgical intervention/ ciclosporin, in conjunction with her neurologist, a weighted decision was made to treat with IFX. She responded very well and developed no neurological complications. She completed IFX induction and is being transitioned to maintenance veodlizumab.

Conclusions
This case highlights the limited treatment options available for rescue therapy in ASUC. Little evidence is available regarding the real world usage of IFX in patients with a history of MS which further narrows the choice for these patients in ASUC. This case supports the use of IFX as rescue therapy in selected patients with MS. More evidence however regarding its impact and safety profile is needed to add weight to this.

TBA (22S155) CASE PRESENTATION

An unexpected cause of GI Bleeding

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Introduction
Background: A 57 year old male presented with a two day history of melaena and bloody diarrhoea. He had a diagnosis of ileo-colonic Crohn's disease and ileal resection in 1992. Due to persistent abdominal pain, his treatment was changed from methotrexate to Adalimumab and then to Infliximab, with minimal objective response

Aims/Background
Case Overview: On arrival to ED, he was hypotensive, tachycardic and cachectic with clinical ascites and right sided abdominal tenderness. Laboratory findings revealed Hb 9.7, CRP 3 and negative stool culture. CT abdomen showed mural thickening involving the small bowel and entire colon and an occluded superior mesenteric vein, which appeared chronic. Gastroscopy revealed a non-bleeding inflammatory lesion in D2. Hb failed to rise despite repeated transfusions and melaena continued. Extensive varices were noted of collateral vessels from the superior and inferior mesenteric veins on CT angiogram. Massive GI haemorrhage led to ventilatory and circulatory support in ICU and an emergency TIPS with immediate improvement in GI bleeding and reduction in vasopressor requirement. Stenting of the occluded SMV was performed with immediate decompression of the associated varices. There were no further episodes of bleeding or diarrhoea. He remains well six months after discharge, off all medications.

Results
Summary: Variceal haemorrhage secondary to chronic total occlusion of the SMV caused life threatening GI bleeding. The venous occlusion was a consequence of longstanding mesenteric fibrosis, which caused portal hypertension with varix formation. Mesenteric fibrosis is a rare condition and not a recognised complication of Crohn's disease

Conclusions
Key Learning: The formation of varices due to mesenteric vein occlusion in the context of mesenteric fibrosis is an exceptionally rare cause of GI bleeding. Cross sectional imaging and angiography are important modalities for the investigation of suspected GI bleeding with non-diagnostic endoscopy.

TBA (22S164) CASE PRESENTATION

Rescue tofacitinib following infliximab failure in a patient with corticosteroid refractory acute severe ulcerative colitis

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Introduction
This case report describes the use of tofacitinib as sequential rescue therapy for acute severe ulcerative colitis (ASUC) in a 23 year old biologic naive male hospitalised with ASUC. Due to corticosteroid-refractory ASUC he received rescue infliximab (IFX) to which he was a non-responder. Tofacitinib salvage therapy was administered following IFX failure during the patients hospitalisation with ASUC. No objective response to tofacitinib was observed and a colectomy was performed.

Aims/Background
A 23 year old male was admitted from endoscopy with ASUC. He had been diagnosed with left-sided ulcerative colitis one month prior in another institution. His symptoms progressed from the time of diagnosis such that at presentation to our institution he was passing 10 bloody bowel motions per day with nocturnal symptoms and abdominal pain. Admitting Truelove and Witts score indicated severe UC. A sigmoidoscopy demonstrated severe mucosal inflammation (eMayo score 3). Biopsies demonstrated inflammatory change, CMV immunohistochemistry was negative. Mayo score at admission was 12. Faecal calprotectin was >1000. Baseline blood work demonstrated WCC 11.2, Hb 15.2 g / L, CRP 29 mg / L, ESR 13, albumin 43g/L.

Method
IV corticosteroids were commenced at admission. Due to a lack of response to corticosteroids infliximab 5mg/kg was administered on day 6 of admission, a second 10mg/kg infusion was administered on day 13 of admission. There was no objective response to two IFX induction infusions. At this stage colectomy was advised as the standard of care management approach. The patient requested information on alternate rescue medical therapeutic strategies.

Results
Following careful multidisciplinary discussion tofacitinib was commenced as a second-line rescue therapy for refractory ASUC on day 21 of admission. A standard Tofacitinib 10mg BD induction dose was administered orally. After four days of tofacitinib induction there was no objective response to therapy and the patient was referred for a subtotal colectomy with ileostomy. Post-operative course was uneventful and the patient was discharged well on day 34 of admission.

Conclusions
In hospitalised patients with corticosteroid-refractory ASUC, who have failed infliximab, tofacitinib may be a valuable therapeutic option, however, careful patient selection and assessment of benefits and risks are required. Larger studies are required to formally evaluate the effectiveness and safety of tofacitinib in corticosteroid-refractory ASUC.

TBA (22S185) CASE PRESENTATION

It's cold inside. Inadvertent Hypothermia during prolonged endoscopy

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Introduction
Hypothermia is a well-recognised complication of abdominal surgery with risk factors including age, low BMI, baseline body temperature, volume of irrigation fluid, and duration of surgery. Little has been reported on the incidence of hypothermia during endoscopic procedures.

Aims/Background
We report a case of an 81-year-old gentleman admitted melena who underwent antegrade enteroscopy to investigate small-bowel bleeding seen at capsule endoscopy.
Method
A significant amount of blood was noted in an area of jejunal diverticulosis during the 55-minute procedure however, the bleeding source was not identified. Approximately 2L of water was infused via foot pump for small bowel irrigation. The fluid warming plate had not been turned on prior to the procedure. Patient was noted to be tachypnoeic towards the conclusion of the procedure but was otherwise stable.

Results
In recovery he developed further tachypnoea and tachycardia with an associated drop in core temperature to 35.3 C. GCS was persistently 13/15. He was noted to be mottled and peripherally shut down. ABG revealed a lactate of 10mmol/L with associated metabolic acidosis with partial respiratory compensation. Workup included the exclusion of myocardial ischaemia, Pulmonary embolism, effect of sedation, sepsis, and bowel perforation. The patient was treated by warming and fluid resuscitation with warmed Hartmann's solution. He recovered well by the next morning and was safely transferred back to referring facility.

Conclusions
Inadvertent hypothermia during endoscopy has rarely been reported. Hypothermia can lead to circulatory insufficiency which causes tissue anoxia, anaerobic metabolism, and excessive lactic acid production. Pre-emptive measures such as warming of irrigation fluid prior to procedure can help reduce the risk.

TBA (22S186) CASE PRESENTATION WITH VIDEO

Over the scope clip for treatment of symptomatic benign tracheo-oesophageal fistula (VIDEO PRESENTATION)

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Introduction
Clinical Case/Video Abstract - Unable to upload video via this form - Have emailed support re same. Headings listed below with ** ** to highlight.

Aims/Background
Background Tracheo-oesophageal fistulae (TOF), characterised by pathological connections between the oesophagus and the trachea or major airways are uncommon in adults but represent a major source of significant morbidity and mortality. Most commonly these occur as a complication of oesophageal or lung cancer (or associated treatment) but fistulae can result from benign inflammatory causes. While stenting of the oesophagus or airway is frequently used to manage malignant fistulae the management of benign fistulae is controversial.

Method
Case Overview An 88 year old female with a history of bronchiectasis and GORD presented with recurrent respiratory sepsis. A barium swallow to investigate for features of aspiration confirmed the presence of a fistula arising from a traction diverticulum in the mid-oesophagus to the proximal portion of the right main bronchus (VIDEO1). The fistula site was visualised at gastroscopy and a single Ovesco (12/6t) over the scope clip was applied to the fistula opening in a satisfactory position (VIDEO2). A subsequent contrast swallow showed the clip in good position and filling of the diverticulum but no passage of contrast through the fistula (VIDEO3). The patient improved clinically with resolution of respiratory sepsis and no further episodes after 4 months of follow up.

Results
Summary This case demonstrates that application of an over the scope clip results in radiological and clinical resolution of benign trachea-oesophageal fistula in the short to medium term and should be considered in cases where surgical repair is not feasible.

Conclusions
Key Learning The case illustrates the importance of careful endoscopic and radiological evaluation to identify benign TOF and the available options for endoscopic management.

Best Clinical Abstracts
Friday 10th June Main Meeting Room - Ballroom

Abstract No.	Title of Paper	First Author's Name	Time
22S106	Oral Ursodeoxycholic Acid Therapy Improves Biochemical, Endoscopic and Clinical Disease Activity in PSC-IBD Patients: A Retrospective, Multicentre Study	Karl Hazel	10.20
22S113	In the Driving Seat with High Resolution Ano-Rectal Manometry	Mary Nwaezeigwe	10.30
22S124	Hybrid advanced endoscopic technique for management of complex gastrointestinal lesions	Anthony McBrearty	10.40
22S140	Use of Platelet-Lymphocyte Ratio and Neutrophil-Lymphocyte Ratio as a Prognostic Marker in IBD	Olga Fagan	10.50
22S174	Utility Of FIT As A Safety Net In Colonoscopy Triage: A Pilot Study In Conjunction With The National Endoscopy Program	Lakshman Kumar	11.00
22S179	A Regional Liver Unit Experience Of Managing Severe Immunotherapy-Induced Liver Injury	Stuart Mcilwaine	11.10

TBA (22S106)

Oral Ursodeoxycholic Acid Therapy Improves Biochemical, Endoscopic and Clinical Disease Activity in PSC-IBD Patients: A Retrospective, Multicentre Study

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Introduction
There is a strong association between IBD and PSC. A diagnosis of PSC-IBD creates a phenotypically different disease than to either alone. UDCA is frequently used in the treatment of cholestatic liver diseases and has been shown to have immunoregulatory effects in PSC. Studies have shown that administration of UDCA led to an improvement in symptoms, liver function tests and histological activity. While the use of UDCA in PSC-IBD is not recommended by guidelines, it remains a widespread clinical practice in Ireland.
Aims/Background
To perform a multicentre, retrospective study to determine the efficacy of oral UDCA treatment in alleviating colitis in PSC-IBD patients.

Method
Patients were identified from local IBD databases from three RCSI group hospitals. Inclusion criteria required patients to be formerly or actively on UDCA therapy. IBD diagnosis, UDCA dose, date of diagnosis, concomitant therapies and clinical scores were obtained from patient's medical records on site. Biochemical markers and endoscopic scores were obtained from electronic records.

Results
Overall, CRP values showed a decrease following the initiation of UDCA ($p<0.0001$). 33.3% of patients had improved endoscopic scores following UDCA therapy. 66.6% of these patients had full endoscopic remission. 33% of patients had clinically active disease prior to therapy, with 4 out of 6 patients having full clinical remission. 61.1% had an improvement in CRP. Non-responders had a shorter duration to PSC diagnosis following IBD diagnosis ($p=0.0008$). Cumulative daily dose of UDCA was higher in the non-responders group when compared to the responders ($p=0.0049$). Mean CRP prior to commencement of UDCA in the responders group was 12.1 g/l (1 – 18.6 g/l) compared to 3.8 g/l (0.58 – 6.6 g/l) following therapy with UDCA ($p<0.0001$). A significant decrease in CRP was observed in the endoscopic responders group ($p=0.0312$). A marked CRP decrease was noted in the non-responders group (34.8 g/l to 7.9 g/l) following UDCA therapy, although patient numbers insufficient to allow for statistical significance in this subgroup. Four patients achieved endoscopic remission following treatment with UDCA, with two patients showing active clinical disease prior to initiation of therapy. Two of these patients showed clinical improvement, with one reaching full clinical remission.

Conclusions
It can be hypothesised that by improving cholestasis in PSC, treatment with UDCA prevents the build up of toxic BA metabolites in the colon and small intestine, reducing their inflammatory effects. As altered BA metabolism is known to play a role in IBD, exogenous UDCA therapy may offer a therapeutic alternative for those with IBD, particularly those with a milder endoscopic and biochemical phenotype. As UDCA is already approved and tested to be safe for human use, less barriers exist to trials of low dose UDCA as a potential therapy for mild IBD.

TBA (22S113)

In the Driving Seat with High Resolution Ano-Rectal Manometry

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Introduction
High-resolution anorectal manometry, part of the investigative process to diagnose disorders of recto-anal co-ordination, is currently performed in the left-lateral position. This may seem unnatural for patients and recent data suggest the seated position may improve rectal drive and recto-anal pressure gradients, raising the question as to whether defaecatory dyssenergia is over-diagnosed when the test is carried out in the left-lateral position.
Aims/Background
A single centre study was carried out in patients with faecal incontinence and/or constipation to evaluate the effect of seated position versus left-lateral position on high-resolution anorectal manometry analysis and resultant manometric diagnosis of dyssenergia.

Method
High-resolution anorectal manometry protocol was carried out in accordance with manufacturer's guidelines (Manoscan). Positioning was consecutive and the order was randomized for each patient. Data analysis and interpretation were blinded with a consensus reached for each test position. Data (mean±SEM) were analysed using an unpaired t-test and Chi square.

Results
40 patients completed the study; 33 female, median age; 56 (IQR 48-63). Mean rectal drive was significantly higher in the seated position v left-lateral position (82.6±5.3mmHg v 44.1±3.9mmHg respectively, $p<0.0001$). No difference in anal sphincter relaxation pressure (66.7±5.7mmHg v 70.9±5.5mmHg, $p=0.9535$). The manometric diagnoses of abnormal anorectal co-ordination was significantly higher in the left-lateral position, $p=0.013$. Patients reported significant preference for seated position, $p=0.0001$.

Conclusions
This data show high-resolution anorectal manometry in the seated position improves rectal drive which reduces manometric diagnosis of abnormal anorectal coordination. These findings may have important implications for practice and may inform future guidelines.

TBA (22S124)

Hybrid advanced endoscopic technique for management of complex gastrointestinal lesions

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Introduction
Endoscopic full thickness resection (eFTR) allows excision of complex upper and lower gastrointestinal (GI) lesions deemed not amenable to conventional endoscopic resection. eFTR appears to be cost-effective when compared to alternative surgical and endoscopic treatment options.

Aims/Background
The aim of this analysis was to demonstrate use of a hybrid advanced polypectomy technique involving advanced endoscopic mucosal resection (EMR) followed by eFTR.

Method
We performed a retrospective snapshot review of 43 patients planned for eFTR with complex (large/difficult-to-access/recurrent/suspicious/residual/neoplastic) gastrointestinal (GI) lesions.

Results
All patients were referred through a dedicated multidisciplinary team meeting (SPECC MDT). All procedures performed as daycase by consultant endoscopists trained in advanced endoscopic resection techniques. Indications included adenomas (51.4%) and early carcinomas (40.5%) amongst other complex lesions. 43 patients were planned for eFTR. Technical success achieved in 86% (37 patients) Male:Female 26:11. Average age was 70.3 years (43 – 88 years). Target lesion size was 10 – 60mm. Average size of eFTR specimen was 20.5mm (9 – 33mm). All lesions completely excised in 83.8%. R0 resection rate was 82.6% for all colorectal cancer lesions. R0 resection rate for a known colorectal cancer was 84.6%. No adverse events were recorded. 7 patients underwent elective surgery with 5 patients demonstrating no residual disease. Endoscopic follow-up was available in 54% (20 patients); no recurrence was detected in colorectal patients.

Conclusions
Hybrid eFTR appears to be a safe and effective therapeutic treatment option for patients with complex gastrointestinal lesions and may avoid need for surgical resection. Further studies are required to evaluate long-term outcomes for patients and cost-benefit implications on service provision.

TBA (22S140)

Use of Platelet-Lymphocyte Ratio and Neutrophil-Lymphocyte Ratio as a Prognostic Marker in IBD

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Introduction
Platelets and PLR have been suggested as a non-invasive biomarker for IBD.

Aims/Background
To assess whether neutrophil-lymphocyte ratio (NLR) and platelet-lymphocyte ratio (PLR) predict response in IBD patients with an acute severe flare.

Method
IBD patients admitted with acute severe colitis between January-2017-December-2019 were assessed.

Results
64-patients (88% UC, 9% CD, 3% indeterminate) were included (55% male, 38yo (11-90yrs)). 33% on biologic therapy at admission. 36% received rescue-treatment (95% infliximab, 5% ciclosporin). There was an association between total platelet count (Z-score 9.76, P=<0.05), NLR (Z-score 9.76, p=<0.05)and PLR (Z-score 9.76, P=<0.05) and risk of colectomy. Patients with colectomy-free-survival at 1-year displayed lower NLR and PLR compared with those who did not (6.7 [1.1-33.0] vs 7.5 [1.7-21.00];p=0.39 and 242 [106-1438] vs 259 [155-1300]; p= 0.11). Patients who received rescue-therapy (n=23), had lower week-8 PLR and NLR and persistence of drug at 6-months (p=<0.05). Lower platelet count and PLR at 8-weeks post rescue-therapy was a predictor of persistence of therapy at 6-months (262 [267-469] v 348 [373-558], p=0.01 and 218 [82-521] v 256 [71-630], p=0.34), conversely CRP was not (8 [1-36] v 2.9 [1-6], p=0.23).

Conclusions
Higher platelet count, NLR and PLR on admission with acute severe colitis are associated with progression to colectomy. NLR and PLR should be considered an important prognostic tool in the assessment of acute severe colitis and when elevated should form part of decision making with respect to early escalation of rescue therapy. Platelet count and PLR at 8-weeks post rescue-therapy may also act as a biomarker for prolonged response to therapy.

TBA (22S174)

Utility Of FIT As A Safety Net In Colonoscopy Triage: A Pilot Study In Conjunction With The National Endoscopy Program

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Introduction
In the post-COVID era, colonoscopy waiting lists are problematic. Faecal Immunochemical Test (FIT) is used nationally in colorectal cancer screening to predict pre-malignant or malignant lesions on colonoscopy but their utility beyond cancer screening has yet to be determined.

Aims/Background
To assess the utility of FIT as a safety net measure in determining the outcomes of patients undergoing non-urgent colonoscopies.

Method
Patients awaiting routine colonoscopy (waiting >3 months) in University Hospital Galway and Letterkenny University Hospital were sent a FIT kit. Positive-FITs (i.e. >50ng/mL) were re-triaged for urgent colonoscopy. Basic demographics, colonoscopy and histology findings were collected, and median FIT levels calculated.

Results
In total, 1226 patients were invited to perform a FIT of which 715 (58%) responded. 115 (16.1%) samples were positive and re-triaged for urgent colonoscopy. Of these, 102 patients underwent a colonoscopy. Median age was 58 years (IQR:47-72). 47.1% were male. Median time to endoscopy from a positive-FIT result was 56 days (IQR:49-62). Most common indications for colonoscopy included altered bowel habit (29.4%) and rectal bleeding (22.5%). Positive findings were seen in 77.5% of procedures (0% malignancies, 43.1% polyps, 33.3% diverticulosis, 11.8% colitis, 9.8% haemorrhoids). High risk adenomas were found in 16 (15.7%) patients. Patients with a FIT ≥1000ng/mL were more likely to have a positive finding compared to those with a FIT of <1000ng/mL (96% vs 72%, p=0.02).

Conclusions
Reassuringly there were no findings of malignancy, although diagnostic yield was high. This highlights the importance of good clinical triage. Further comparison with the negative-FIT group after colonoscopy and patient reported outcomes are being followed-up in this study.

TBA (22S179)

A Regional Liver Unit Experience Of Managing Severe Immunotherapy-Induced Liver Injury

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Introduction
Immune-mediated hepatitis is a recognised complication of checkpoint inhibitor immunotherapy drugs, occurring in up to 17% of patients receiving dual therapy. The primary oncology team manage grade 1 & 2 liver injury patients based on local guidelines. Grade 3 & 4 liver injuries are referred to the Regional Liver unit and managed jointly with the liver team.

Aims/Background
We report the RVH Liver unit's experience of the management and outcomes of severe (grade 3 and 4) cases in the period Jan 2019 -Jan 2022.

Method
Patients were identified via consultant and ward records and were reviewed using the NI electronic care record (NIECR). Primary malignancy type, grade of liver injury, management and outcomes were noted.

Results
14 patients required input from RVH Liver team. 12 had metastatic melanoma. 1 had metastatic renal cell carcinoma. 1 had non-small cell lung carcinoma. 9/14 patients received combination Ipilimumab/Nivolumab. 4 received Pembrolizumab, whilst 1 patient received single agent Nivolumab. 8 patients had grade 3 liver injury, with 6 grade 4 cases. 12 patients were treated with a combination of prednisolone and mycophenolate mofetil. 5 of these patients required the addition of tacrolimus. 2 patients received prednisolone and tacrolimus. A complete biochemical response was achieved in 12 cases with a partial biochemical response in the other 2 cases. Of the 2 cases with persistently deranged liver biochemistry: 1 had coexisting fatty liver changes and the other developed hepatic metastasis.

Conclusions
Joint hepatology and oncology collaborative care is beneficial to patients with severe immunotherapy-induced hepatitis as a serious adverse effect of immunotherapy. Our cohort of patients with severe immunotherapy-induced hepatitis did well, with all patients responding to immunosuppression. Tacrolimus is useful for resistant cases.

Best Scientific Abstracts
Friday 10th June Dublin Suite

Abstract No.	Title of Paper	First Author's Name	Time
22S132	Higher body fat mass and waist circumference and lower thigh muscle thickness and function are observed in IBD patients using bioelectrical impedance analysis and anterior thigh ultrasound	Neasa Mc Gettigan	10.20
22S133	The Role Of Viral Agents In Progression From Barrett's Oesophagus To Oesophageal Adenocarcinoma: A Population-Based Nested Case-Control Study.	Talita H A Oliveira	10.30
22S137	Medications affecting the renin-angiotensin system and colon cancer survival by molecular characteristics: a population-representative study	Yasemin ADALI	10.40
22S146	The Impact of Drug Levels to Anti-TNF and Anti-Integrin Agents on COVID-19 Vaccine Response in Patients with Inflammatory Bowel Disease	Jayne Doherty	10.50
22S162	PCR improves detection of H. pylori in unselected adult patients undergoing routine gastroscopy.	Thomas J. Butler	11.00
22S165	The Notch pathway transcription factor HES1 regulates expression of the pro-inflammatory cytokine IL-8 during H. pylori infection	Rebecca FitzGerald	11.10

TBA (22S132)

Higher body fat mass and waist circumference and lower thigh muscle thickness and function are observed in IBD patients using bioelectrical impedance analysis and anterior thigh ultrasound

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Introduction
US measurement of thigh muscle thickness in IBD is not validated. Sarcopenia (low muscle mass, strength and function) and visceral obesity are associated with adverse outcomes in IBD.

Aims/Background
Validation of anterior thigh US for measurement of total muscle thickness (TMT) and fat thickness (FT) in IBD patients and identification of muscle thickness values associated with sarcopenia using bioelectrical impedance analysis (BIA).

Method
A prospective study of muscle function and mass using B-mode US and BIA (SECA mBCA 525) is being carried out in IBD patients. Stata was used for statistical analysis, $p< 0.05$ denoting statistical significance.

Results
19 IBD patients (13 CD, 5 UC, 1 IBDU) and 7 healthy controls (HCs) are included to date. Most IBD patients were male n=15, mean age=48yrs, median CRP=2mg/l (IQR 1,13). Intra-rater correlations for TMT and FT by US positively correlated (r=0.94,p<0.0001; r=0.97,p<0.0001). Using thigh US, mean TMT=3.98cm (SD 0.93) and FT=1.24cm (SD 0.54) with lower TMT in IBD vs HC (p=0.025). Thigh FT correlated positively with body fat % (r=0.754,p=0.0003) and body fat mass (r=0.629,p=0.005). Visceral fat correlates with waist circumference (r=0.93,p=<0.0001), weight (r=0.668,p=0.0025) and increasing age (r=0.745,p=0.0004). Mean fat mass (p=0.021) and waist circumference (p=0.01) were greater in IBD patients vs HC despite similar BMI. Hand grip-strength correlated with skeletal muscle mass (r=0.530,p=0.024) in IBD. Sit-to-stand time was lower in HCs (7.7 vs 13.4secs,p=0.005) and HCs were more active (p=0.025).

Conclusions
Preliminary results show higher fat, lower muscle thickness and reduced muscle performance in IBD patients. Further recruitment is underway to increase sample size, ensuring external validity.

TBA (22S133)

The Role Of Viral Agents In Progression From Barrett's Oesophagus To Oesophageal Adenocarcinoma: A Population-Based Nested Case-Control Study.

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Introduction
Infectious agents have a causal role in the development of several neoplasms, including head and neck cancer. Recent evidence suggests that human papillomavirus (HPV) may be associated with an increased risk of oesophageal adenocarcinoma (OAC), though mostly from cross-sectional data.

Aims/Background
To investigate the presence of infectious agents, including HPV and Epstein Barr virus (HBV), in tissue from Barrett's oesophagus (BO) patients who subsequently progressed to high grade dysplasia (HGD) or OAC compared with non-progressors.

Method
FFPE samples from BO patients who progressed to HGD/OAC (n=150) and non-progressors (n=316) matched based on age, sex, and Trust, were retrieved from each Trust and the Northern Ireland Biobank. Sections were cut using a strict procedure to avoid cross-contamination. DNA was extracted and viral DNA amplified by a multiplex polymerase chain reaction (PCR) protocol, followed by identification of viral DNA (126 known carcinogenic agents) using a Luminex-based platform.

Results
HPV was present in 33 of 466 (7%) BO patients, with no difference between progressors and non-progressors. High-risk HPVs were rarely found (n<10) but were only found in progressors. EBV , Polyomavirus and herpes viruses were rarely found (<4%), with no difference between cases and controls.

Conclusions
This study did not find evidence to suggest that HPV is common in BO patients. However, as high-risk HPV subtypes were only found in progressors, further research using similar strict anti-cross-contamination procedures are required to investigate whether high-risk HPV are a rare causal contributor in progression from BO to OAC.

TBA (22S137)

Medications affecting the renin-angiotensin system and colon cancer survival by molecular characteristics: a population-representative study

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Introduction
The safety of use of angiotensin-converting enzyme inhibitors (ACEI) and angiotensin receptor blockers (ARBs) in colorectal cancer (CRC) patients is still debated.

Aims/Background
To investigate if the relationship between ACEI and/or ARBs and survival in Stage II and III colon cancer patients differs according to molecular biomarkers (MSI, BRAF, KRAS, NRAS, MET, PIK3CA, P53).

Method
The association between ARBs and ACEI use and biomarkers in relation to survival outcomes was examined in a population-based cohort of 587 colon cancer patients diagnosed in Northern Ireland from 2004 to 2008 and followed up to December 31st, 2013. Medication exposure was captured at the time of diagnosis/treatment. Cox proportional hazards models were used to calculate hazard ratios (HRs) and 95%CI for CRC-specific death and overall death.

Results
ARB and/or ACEI use was not associated with survival in colon cancer patients. CRC-specific survival was poorer in patients using ARBs who had BRAF-mutant tumours, although this analysis was based on only 7 ARB users. There was some evidence of poorer overall, but not CRC-specific, survival outcomes in ARB users who had PIK3CA and P53-mutated tumours. There was no association found between the usage of ACEI alone or in combination with ARBs and survival in colon cancer patients.

Conclusions
Overall, medications affecting the renin-angiotensin system do not influence survival outcomes in colon cancer patients, however, there was suggestive evidence of poorer outcomes in patients with BRAF-mutant tumours. Further investigations are necessary in other large population-based studies to test these findings.

TBA (22S146)

The Impact of Drug Levels to Anti-TNF and Anti-Integrin Agents on COVID-19 Vaccine Response in Patients with Inflammatory Bowel Disease

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Introduction
Patients with inflammatory bowel disease (IBD) receiving biologic agents, especially anti-TNF agents have reduced response rates to COVID-19 vaccination. The reason for this is unclear and whether a patient's drug level at the time of vaccination impacts response is unknown.

Aims/Background
Determine if a patient's drug level to biologic agents at the time of COVID-19 vaccination impacts antibody response.

Method
IBD patients and healthy controls (HC) were recruited prospectively from five centres and quantitative antibody responses and drug levels assessed following COVID-19 vaccination.

Results
270 IBD patients and 116 HCs were recruited. Median age was 39.5 years. 145 patients were treated with anti-TNF therapy. Median anti-spike protein (SP) immunoglobulin (Ig)G levels post-complete vaccination in our IBD cohort was significantly lower than HC (2,613 AU/mL versus 6,871 AU/mL, p=<0.001). IBD patients receiving anti-TNF therapy had significantly lower anti-SP IgG levels (2,445AU/mL) than those not receiving TNF-inhibitors (3868AU/mL) ($p = < 0.001$). 99 patient's treated with infliximab, 24 with adalimumab and 12 with vedolizumab had drug levels at the time of vaccination. We found no significant correlation between SP IgG levels post-vaccination against COVID-19 and IFX levels (correlation co-efficient -0.17, $p = 0.09$), adalimumab levels (correlation co-efficient -0.28, $p = 0.24$) or vedolizumab levels (correlation co-efficient -0.11, $p = 0.74$). Low drug levels to biologic agents did not impact SP IgG levels. Median SP IgG levels in patients with low drug levels were 3081AU/mL versus 2235AU/mL in those with adequate levels ($p = 0.16$).

Conclusions
Although IBD patients receiving anti-TNF agents have reduced antibody response to vaccination against COVID-19 a patients drug levels at the time of vaccination does not impact antibody response for those receiving anti-TNF or anti-integrin agents. We are currently exploring other mechanisms of action for the reduced response seen in IBD patients.

TBA (22S162)

PCR improves detection of H. pylori in unselected adult patients undergoing routine gastroscopy.

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Introduction
Accurate detection of H. pylori infection is essential for the effective patient management. Reduced prevalence and wide usage of PPI's can negatively impact commonly employed tests; including rapid urease tests (CLO), culture-based techniques and standard histological examinations. Additional tests in at risk patients could improve detection.

Aims/Background
To compare the performance of a PCR based assay for the detection of H. pylori verses routine histological testing in an Irish context.

Method
Adults were prospectively recruited. Following ethical approval and informed consent, during routine gastroscopy subjects had 2 additional antrum and corpus biopsies taken for DNA extraction and PCR testing, using commercially available urease primers. Antral and corpus histology was performed as standard (H&E and IHC where indicated) in the hospital laboratory.

Results
In all, 118 patients with available histology and PCR results were included in the final analysis, N= 118. In all, 27 had CAG, of which 21 (78%), 20 (74%) and 13 (48%) had positive histology, PCR and CLO tests respectively. Of interest, in 44 subjects with chronic inactive gastritis (CIG), 11 (25%) had a positive PCR and only 1 (2%) positive histology. In all PCR detected the urease gene in 31 (26%) patients indicative of infection, 20 and 11 with CAG and CIG respectively. Based on PCR the sensitivity, specificity, PPV and NPV for histology was 65%, 98%, 9% and 89% respectively.

Conclusions
PCR based testing should be included in cases where no HLO are detected on routine histology, particularly if the patient has a presentation of chronic gastritis irrespective of activity.

TBA (22S165)

The Notch pathway transcription factor HES1 regulates expression of the pro-inflammatory cytokine IL-8 during H. pylori infection

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Introduction
Accumulating evidence supports an important role for the Notch pathway transcription factor HES1 in inflammation and immunity.

Aims/Background
To determine the expression and function of HES1 during H. pylori infection.

Method
Gene expression in response to H. pylori was measured by RT-qPCR in AGS gastric epithelial cells, THP-1 macrophages and antral biopsies from infected and uninfected patients. For HES1 over-expression, AGS cells were transfected with either pCMV6-HES1 (NM_005524) Human Tagged ORF Clone (ORIGENE) or with pCMV6-AC-GFP control vector (ORIGENE) using Lipofectamine LTX® reagent (Thermofisher). The Student's T-test and Mann-Whitney U-test were used to compare results in cell culture samples and tissue biopsies, respectively. A P value of <.05 was considered significant.

Results
H. pylori infection led to a significant decrease in HES1 mRNA expression in AGS epithelial cells and THP-1 macrophages. Furthermore, a 38% decrease in HES1 levels was observed in the gastric mucosa of H. pylori-infected patients (N=25) compared to uninfected controls (N=17; P=0.02). Using a gain-of-function approach, HES1 plasmid transfection was effective at increasing the expression of HES1 >2,000 fold, compared to un-transfected cells and empty control vector samples in AGS cells (P=.004 and P=.004, respectively). H. pylori-mediated induction of the pro-inflammatory cytokine IL-8 was significantly augmented in cells over-expressing Hes1 (224-fold) compared to un-transfected (91-fold; P<.001) or control vector transfected cells (102-fold; P<.001).

Conclusions
HES1 over-expression in AGS cells augments IL-8 induction, implying that the H. pylori-mediated decrease in HES1 expression restrains IL-8. Further research will be required to identify more targets of H. pylori-mediated HES1 suppression.

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